COVERED CALIFORNIA SMALL BUSINESS EMPLOYER GUIDE

COVERED CALIFORNIA
SMALL BUSINESS

Rev 2.05.2020

WELCOME TO COVERED CALIFORNIA SMALL BUSINESS

Covered California Small Business (CCSB) is a part of California's State Health Benefit Exchange where employers with 100 or fewer Full-Time Equivalent Employees (FTEs) can access brand name health insurance plans in order to provide quality, affordable health coverage for their business.

With multiple health and dental insurance companies and plans to choose from, employers like you can offer increased flexibility and choice to your employees. Covered California Small Business is also the only place where small businesses can qualify for the federal health care tax credit.

We provide you with clear defined levels of coverage—Platinum, Gold, Silver, and Bronze—to simplify the process of selecting from dozens of available health plans. You can choose not only one, but two adjoining levels of coverage. For example, you can set your budget on the silver level, but allow employees to move up to gold.

As an enrolled employer, we strive to provide you with the highest level of service to make it easy for you to offer health insurance. Our Certified Insurance Agents and Small Business Service Center are available to ensure that both you and your employees find the coverage you need and at a budget you can afford.

We're here to help! CCSB is committed to supporting your small business, and we invite you and your employees to contact your Certified Insurance Agent or our Small Business Service Center at (855) 777-6782.

You may also visit the CCSB website at *CoveredCA.com/ForSmallBusiness* for a number of additional resources that may be useful to you.

MyCCSB PORTAL!

Access to your employees' account information made easy. The MyCCSB portal offers easy web-based access to all your group enrollment and account information. Best of all, this paperless function provides faster processing. Use the portal to perform essential functions such as renewal changes, accessing your invoices, and viewing your current balance all from the convenience of your desktop computer.

Features and benefits of the MyCCSB Portal include:

- Initiate employer/employee application process
- Access employer dashboard
- Access to employer invoices
- Review employees' eligibility status and carrier assignment
- View eligibility transactions
- Process Adds and Terminations for Employee(s)
- Upload Change Forms for Employees
- Pay your monthly invoice online

To access the MyCCSB Portal visit

https://myccsb.com

Creating a login:

1. Click the "***Employer Registration***" button.
2. Enter the required information from your last invoice: the premiums for that period, the total amount due, the Employer Group ID and the invoice number.
3. Create a password.
4. You will receive a follow up email and will confirm your account by clicking the provided link.

TABLE OF CONTENTS

RESPONSIBILITY AND PRIVACY

Your Health Plan Responsibilities

While CCSB handles most of the administrative work to make offering health coverage easy for you as a business owner, you will have some responsibilities that you should be familiar with as a health plan sponsor. To provide a quick summary, you are responsible for the following when offering company- sponsored health coverage through the CCSB program:

1. Knowing Your FTEs Count and Applicable Large Employer Status
2. Meeting CCSB Eligibility Requirements
3. Determining Your Level of Health Coverage and Premium Contribution
4. Following Privacy Rules
5. Deciding on Employee and Dependent Eligibility
6. Setting a New Hire Election Period
7. Paying Your Monthly Invoice
8. Providing CCSB with Notices of Eligibility Changes
9. Notifying Employees of Open Enrollment
10. Identifying COBRA regulations and Notifying Terminated Employees of COBRA.
11. Providing Employees with Health Plan Documents & Resources

In these pages, you will find information on each one of your responsibilities along with details that can help you manage a health insurance program for your employees. These include things like understanding privacy rules, knowing which of your employees are eligible for coverage, what to do if you need to make a change to your health coverage, or when and how to pay your premiums. Feel free to reference the table of contents found at the beginning of this guide for quick access to key topics or the last few pages of this guide for helpful resources and important phone numbers should you need further assistance.

Privacy Guidelines

When applying for health insurance, you and your employees are required to reveal confidential information. Protecting this information is of utmost importance to CCSB. Any information collected on a CCSB employer or employee application, other than the name, address, birth date, and plan selection(s), will not be shared with you or a selected health insurance plan unless strictly necessary for the purposes of determining eligibility and enrollment. As a health plan sponsor, it's important for you to remember to be cautious when disclosing sensitive and personal information. Always adhere to applicable privacy rules to ensure the health information of your employees remains confidential and protected. To review Covered California's privacy practices, please visit: www.coveredca.com/privacy.

Employer Eligibility Guidelines

To be eligible for CCSB, you must have 100 or fewer FTEs. Additional requirements are:

- Employer's principal business address must be in California or offer coverage to each eligible employee serving that employee's primary worksite
- At least one employee* must receive a W-2; employee cannot be an owner or spouse of an owner
- Employer must offer CCSB coverage to all eligible FTEs
- Employer must agree to the employee participation requirement
- Employer must agree to contribute at least 50 percent of the lowest cost employee-only plan in your select level of coverage for your eligible employees' premiums.

Counting Full-Time Equivalent (FTE) Employees

Only small businesses with 100 or fewer FTEs are eligible to enroll in CCSB. Calculating your total FTE count is your responsibility as an employer.

An FTE calculation includes all full-time and part-time employees who worked during the prior calendar year (or who are reasonably expected to work in the current calendar year if you did not exist as a company in the prior year). The calculation should also include employees employed by related entities meeting controlled group status under federal tax laws. To assist you in estimating your FTEs count, we encourage you to visit the *IRS.gov/Affordable-Care-Act* website and review the IRS-related Affordable Care Act resources made available to you.

Although the total FTE count determines your business' eligibility to participate in CCSB, it's important to note that not every employee may be eligible for coverage (See **Employee Eligibility & Verification**).

Did You Know?

If your FTEs should increase beyond 100 throughout your plan year, you will continue to remain eligible for CCSB provided other eligibility standards are met. Should you elect to terminate your health coverage with CCSB but want to reapply later, you may no longer be eligible to participate if your FTEs count has exceeded 100 employees.

EMPLOYER ELIGIBILITY GUIDELINES

Knowing Your Small and/or Applicable Large Employer Status

Applicable Large Employers

The Affordable Care Act (ACA) is a federal law that changed the health care landscape for the United States in 2010 that requires employers of a certain size (50 or more FTEs) to offer health benefits coverage. These employers are known as "Applicable Large Employers" (ALEs).

The mandate requires that if you have 50 or more FTEs you must offer health coverage that is both "affordable" and that meets a "minimum value" to your employees. The law also requires ALEs to offer coverage to employees for their dependent children below the age of 26. ALEs that do not offer health coverage could face a penalty from the Internal Revenue Services (IRS) referred to as the Shared Responsibility Payment. This penalty is triggered when an employee who is not offered coverage by an ALE purchases health insurance on a state or federal health exchange and receives a federal subsidy to help pay for that coverage.

If you have less than 50 employees, you are considered a small business by the ACA and are not legally required to offer health coverage. Regardless whether you are a small or large business, you may find that by offering health coverage it will help to attract top talent and improve productivity for your business. Providing employees with health coverage has also been demonstrated to increase morale and help with a company's retention, making the business an attractive employer for employees.

Offering coverage through CCSB can help you avoid the Shared Responsibility Payment and provide your employees with access to quality, affordable ACA-compliant health plans. For more information on the Employer Mandate, visit *CoveredCA.com/ForSmallBusiness/Mandate*.

Small Business Group Size in California

California recently expanded the group size definition of a small business to include any business with at least one but no more than 100 FTEs. Historically, small group size in the health insurance industry was determined for employers that had up to 50 FTEs. With the recent expansion, employers with 51- 100 FTEs are now also considered a "small group". CCSB changed its eligibility requirements to align with the state expansion of small group, which means that employers with up to 100 FTEs may be eligible to enroll in the program.

Did You Know?

The difference in federal and state legislation means that it is possible for you to be considered both an ALE (those groups with 50 or more FTEs), as defined by the ACA, and still be considered a small business with respect to California state law. Employers with 50 to 100 FTEs are considered both eligible for coverage through CCSB program but also required to offer health coverage as an ALE.

Employer Contribution Requirement

If you are eligible to participate in CCSB you are required to contribute at least 50% of the cost towards the lowest premium available for employee-only coverage. This means that you must pay for at least 50% of the employee-only premium for the reference plan that you choose. This reference plan can be on any level of coverage, but you will be required to pay, at a minimum, at least half of the cost of this plan. Your employees' premium contribution and out-of-pocket costs will depend on your reference plan and total contribution, your selected level(s) of coverage and the plan(s) your employee selects. There is no minimum dependent contribution requirement.

Employee Participation Rate Requirement

When offering coverage through CCSB, at least 70% of your eligible employees must enroll with CCSB. Valid waivers are not counted when calculating participation. Valid waivers may include:

- Employer Sponsored Coverage
- Military coverage
- Medi-Cal
- Medicare
- Other federal or state health coverage programs other than coverage through a Qualified Health Plan (QHP) sold in the Individual Exchange

Annual Special Enrollment Period

If you should fail to meet the employer contribution or minimum employee participation rate requirements, CCSB offers an Annual Special Enrollment Period every year from November 15 to December 15 where employers that meet all other eligibility guidelines will be allowed to enroll for health coverage starting January 1.

You can enroll in CCSB at any time throughout the year, however excluding the Annual Special Enrollment Period, you must have at least 70% of your employees enroll in a health plan and contribute at least 50% of the cost towards your employees' premiums.

Did You Know?

During a limited time, each year, from November 15 to December 15, CCSB allows employers that have not met its minimum participation rate and/or premium contribution requirements to enroll in a health plan. This annual special enrollment period allows you to enroll even if only a few employees accept coverage, and when you're unable to meet the premium contribution requirement.

Offering Infertility Coverage

Infertility coverage is an elective benefit that you can choose to offer as part of your health plan program.

Employers with 20 or more FTEs:

- Employers with 20 or more FTEs who choose to offer Infertility benefits to their employees, all products shall include Infertility benefits.
- Employers with 20 or more FTEs who choose to not offer Infertility benefits to their employees, all products shall not include Infertility benefits.

Employers with less than 20 FTEs:

- Employers with less than 20 FTEs have the option to include Infertility benefits only on Non-HMO plans.

Employer Eligibility & Verification

CCSB will verify your eligibility as a business owner prior to allowing you to offer health insurance coverage to your employees. If you are determined eligible, CCSB will notify you in writing confirming that you can participate. If there are any errors in your eligibility, CCSB will provide you written notice of the discrepancy. From the date of notice, you will have 30 days to resolve any eligibility issues. If you choose not to act within that 30-day period, CCSB will provide an eligibility denial notice in writing to you.

Employee Eligibility & Verification

Employees are eligible to participate in CCSB if they receive an offer of coverage from you as an eligible employer and are permanently employed full-time. Employees that are considered "full-time" work an average of 30 hours per week over the course of a month. Eligible employees may be added during the plan year if they experience a qualifying life event or during your annual open enrollment period. Effective dates for coverage are always the first of the month.

Did You Know?
Part-time employees may be considered eligible at your discretion. In order to be counted in your participation rate calculation, part-time employees must work between 20 and 29 hours per week and be actively engaged in your business. In other words, these employees cannot be independent contractors (receive a Form 1099), temporary employees or work less than 20 hours a week for your company.

Employees who are **not** eligible for coverage include those employees who work less than 20 hours per week, receive a Form 1099 or are seasonal, temporary, or subject to collective bargaining arrangements through a union.

CCSB verifies that your employee is eligible when you submit your application for coverage and will collect only the minimum information necessary to verify their eligibility and enrollment. When your employees' eligibility is determined, we will provide them written notice along with information on their right to appeal their eligibility determination.

If there are inconsistencies between your company and employee applications, CCSB will provide you a written notice. You will have 30 days from the date of the notice to resolve the inconsistency. If no response is received within the 30-day period, CCSB will provide a written notice of denial to enroll in the program.

Your employee may voluntarily elect to waive coverage. The employee must complete and sign the declination section on the employee application. An employee that waives their coverage is not eligible to enroll in your health plan until your next open enrollment period or unless eligible for a special enrollment period through a qualifying event.

Dependent Eligibility & Verification

Did You Know?
Spouses, as well as registered and non-registered domestic partners, are not considered "eligible dependents" and should seek their own coverage either through their employer, Covered California's Individual Marketplace or a private health insurance company. You may elect to offer dependent coverage that includes spouses or domestic partnerships, but it is not required when electing to offer dependent coverage.

Should you elect to offer dependent coverage, enrollees and their dependents must enroll in the same health and/or dental plan. Dependents that qualify and are eligible for health coverage through CCSB must be under the age of 26. Dependents include adopted children, foster children or those under legal guardianship. Disabled adult children (regardless of age) are also considered eligible dependents. Only dependents under the age of 19 are eligible for the pediatric dental and pediatric vision coverage. Please refer to your selective Evidence of Coverage (EOC) for more information. If the selected health plan does not include embedded Pediatric Dental, the employee has the option to select a supplemental children's dental plan. Dependents that lose eligibility for pediatric dental coverage subsequent to turning nineteen (19) years of age and wish to continue dental coverage under a standalone dental plan may select a standalone dental plan within 30 days of losing coverage. Eligible dependents may be added during the plan year if they experience a qualifying life event or during your annual open-enrollment period.

Did You Know?
You can elect to offer employee only-coverage. If you choose to offer employee-only coverage, know that you may be subject to Shared Responsibility Payments if you are an ALE and your employees' dependent children seek coverage through a state or federal health exchange. However, if you should elect not to offer dependent coverage and are not required to because of your business size, your employees may be able to purchase coverage for their dependents through Covered California's Individual Marketplace. Dependents may even be eligible to receive financial assistance for a health plan should they need it.

In verifying eligibility for your employee's dependents, we will provide written notice if there are inconsistencies between your company and employee applications. You'll have 30 days from the date of the notice to resolve the inconsistency. If no action is taken within that 30-day period, CCSB will provide written notice to your employee about their dependent's denial of eligibility to enroll in the program.

ELIGIBILITY APPEAL PROCESS

If you or your employees receive a denial of eligibility or do not receive timely notification of eligibility from CCSB, you have the right to appeal the decision. Appeals must occur within 90 days from the date of the denial notice. Once an appeal is submitted, CCSB will provide a response to the appeal in writing. Appeals will be decided independently, and the appeal board will review all evidence submitted by the appellant. If you as a business owner or your employees are determined to be eligible for health coverage as a result of the appeal process, the eligibility decision is backdated and effective starting the date of the incorrect determination.

Appeals must be submitted in one of the following ways:

1. **Delivered in-person or mailed to:**
   CA Department of Social Services
   ATTN: ACA Bureau
   P.O. Box 1944243
   Mail Station 9-17-37 Sacramento,
   CA 94244

2. **Submitted electronically to:**
   SHDACABureau@dss.ca.gov

3. **Or by fax to:** (916) 651-2789

For questions regarding the appeals process, contact the CCSB Service Center at (855) 777-6782.

REPORTING CHANGES TO CCSB

Reporting a Change to Your Business

Several events can occur throughout the year that can impact your business. You may change your ownership structure, your business name or primary contact, your address or your federal and state tax ID. These are important changes and it is your responsibility to notify CCSB promptly.

If your principal business address should change, know that it may affect premium rates and/or plan options for both you and your employees (see **Your Premiums & Payments** on pg. 12-13). However, CCSB will not make retroactive rate changes for employers that fail to inform us of address changes. Premium and rate changes will only be effective at your plan year renewal.

Please notify us of a business change by completing and submitting an Employer Change Request Form to CCSB. Employer Change Request Forms can be found at CoveredCA.com/ForSmallBusiness/Resources and should be submitted using one of the following methods below:

Reporting a Change in Employee/Dependent Eligibility

As a health plan sponsor, you are required to report any changes in your employees' eligibility to CCSB. Changes that should be reported include an employee's:

- Change of address
- Change in work hours or work relationship
- Loss or gain to other health coverage
- Change in dependent status
- Termination of employment
- Death

All changes should be submitted using an Employee Change Request Form within 30 days. Employee Change Request Forms can be found at CoveredCA.com/ForSmallBusiness/Resources in both English & Spanish. Forms should be submitted to CCSB using one of the following methods below:

To access the MyCCSB Portal: https://myccsb.com

Email:	CCSBeligibility@covered.ca.gov
Fax:	949-809-3264
U.S. Mail:	Covered California Small Business/CCSB P.O. Box 7010 Newport Beach, CA 92658

Please allow one to two billing cycles for your employee or dependent change to be updated in our system and on your monthly invoice.

Making Changes to Your Health Coverage

Once enrolled in CCSB, you or your employees can only make changes to health coverage during your annual election and open-enrollment period. After enrolling, eligible employees can make changes to their selected health plan during the first 30 days of the new plan year, provided the newly selected health plan is offered by the same issuer. Plan changes received between the 1st and 15th of the month will be effective retroactively to the 1st of the month, unless the employer requests an effective date of the first of the following month. Plan changes received between the 16th and 30th of the month will be effective the 1st of the following month. Changes made during this time include:

- Level of coverage (Bronze, Silver, Gold, Platinum) and/or the option to add a second level of coverage through CCSB's Dual Tier Choice option
- Reference Plan
- Contribution percentage
- Number hours of work necessary for coverage
- Update number of FTEs
- Dependent coverage
- Infertility coverage

If your reference plan is no longer available at renewal and you do not select a new reference plan during your annual election period, a default plan will be auto selected on your behalf. The auto-selected reference plan shall be the lowest cost plan in your current selected tier and your contribution will remain the same as previously elected.

During your annual Open Enrollment, employees can make plan changes within your selected level(s) of coverage, add dental coverage and/or dependents.

If at renewal an employee's plan is discontinued, the employee's plan may be passively renewed to the lowest cost plan within the same carrier and same metal tier. If the same carrier is not available with CCSB, the employee's plan may be passively renewed to the lowest cost plan with a different carrier within the same metal tier. Please refer to your Renewal packet for details.

Employees can make changes to their health coverage throughout the plan year should they experience a qualifying event. For more information on what changes can be made during these time periods, see **Qualifying Life Events – Special Enrollment**.

YOUR PREMIUMS & PAYMENT FOR HEALTH COVERAGE

Your Premiums

Health coverage and premiums are guaranteed for 12 months from your initial coverage effective date. The premiums you pay for your health plan are based on your business address. There are 19 rating areas in California based on region and zip code that determine the amount of financial adjustments that are made to your health insurance premiums.

Additionally, changes to your health plan premiums at your plan year renewal may account for changes to your employee participation, changes in cost sharing, and the age of your employees and their dependents.

Making Premium Payments

Initial Payment

Although employees can choose from multiple health insurance plans, you pay CCSB directly with one payment for the covered month. It is important CCSB receive a minimum of 85% of the first month's premium by the first of the coverage month. CCSB coverage will not take effect until payment is received. Failure to send in prompt payment will delay your effective date or require you to resubmit your enrollment materials.

Ongoing Payments

The billing cycle for all plans is the 1st of the month. CCSB will send you an invoice on or about the 15th of each month for your employees' health insurance coverage for the following month of coverage. Health care premiums are due **prior to the new month of coverage**.

You are expected to pay the total balance owed. Failure to submit payment for at least 85% of the total balance due may result in delinquency and cancellation of your health coverage. This payment amount includes any amounts that are past due. If the minimum amount is not paid or postmarked by the due date indicated on the invoice, CCSB will mail a notice of delinquency on the day after payment is due explaining the terms of a 30-day grace period which will include instructions for making the premium payment necessary in order to maintain coverage in force and provides notice of your right to request review of the cancelation by the applicable regulator. If coverage is terminated due to non-payment, you will be notified of the reason and the termination date within three business days electronically or five business days through U.S. Mail.

If you are terminated for non-payment, you may request to be reinstated in the same coverage in which you were last enrolled within 30 days after the effective date of termination and all past due payments must be made prior to reinstatement without a lapse in coverage. You can only be reinstated once in a 12-month period. If you are terminated for non-payment for31 or more days following the effective date of termination, you must reapply for a new group policy.

Note: *You will receive a separate invoice for your COBRA participants, requiring a separate payment for these individuals*.

Grace Period

A grace period of 30 days will be allowed for payment of any premium due after the initial premium. If full premium is not received on or before the expiration of the 30-day grace period, coverage will cease automatically and terminate upon the last day of the 30-day grace period. A final termination notice will be sent to you and your associated employees if full premium due is not received on or before the expiration of the 30-day grace period. Pursuant to California's State Accounting Manual's collection policies, CCSB will send a sequence of three collection letters at 30-day intervals. If a response to the third letter is not made within 30 days, CCSB will pursue other collection methods which include and are not limited to assigning the debt to a third-party collection agency.

See State Accounting Manual (SAM) section 8776.6.

Premium payments can be made online in the MyCCSB portal:

To access the MyCCSB Portal visit: https://myccsb.com.

Or sent via US Mail to:

Covered California Small Business/CCSB
P.O. Box 740167
Los Angeles, CA 90074-0167

Overnight Payment to:

Bank of America Lockbox Services
Lockbox LAC-740167
2706 Media Center Drive
Los Angeles, CA 90065

Dishonored checks, stopped payments, or non-sufficient funds could result in delinquency of payment. CCSB will apply a $25 return fee for any of the accepted payment methods that result in insufficient funds.

If more than one returned payment is made in a six-month period, you must submit premium payments in the form of a cashier's check or money order for a period of 12 months beginning the first of the month following the last paid through date. In no event will the failure to pay the insufficient funds fee be a basis to terminate, non-renew, or cancel coverage pursuant to Health and Safety Code Section 1365 or Insurance Code Section 10753.13, as applicable.

ENROLLING YOUR EMPLOYEES

Annual Election and Open Enrollment Period

Open Enrollment is the time of year when your small business is eligible to change its offer of health coverage to employees. CCSB will send you a written notice of your plan renewal and annual election period 60 days prior to the completion of your plan year. During this time, you can explore plan options and make necessary reference plan and/or contribution changes to your health coverage (See **Making Changes to Your Health Coverage**). The election period for you to make changes to your offer of coverage is at least 20 days in length, beginning on the day that CCSB sends you the written notice of your annual employer election period.

Once you have made your health coverage changes, if any, you can start an open-enrollment period for your employees to make their health plan selections for the upcoming plan year. The open-enrollment period for your employees must be at least 20 calendar days in length. During Open Enrollment, employees can review their plan options, discuss buying decisions with their family and make plan changes the upcoming plan year. They may also add and terminate eligible dependents.

Open Enrollment Notifications

At the start of your annual open-enrollment period, CCSB will provide you with a renewal packet that includes instructions for renewing your health or dental plan, making plan changes, and provide renewal sheets for each employee with information about his or her existing coverage and premium rate changes. The renewal packet will also include both an Employer and Employee Change Request Form that you and your employees must use to make changes to your health coverage.

Once you receive a renewal packet from Covered California, it is your responsibility to notify your employees and any Federal COBRA (see **COBRA Health Plan Administration** on pg. 20) participants of:

- Their right to change their health and dental coverage during Open Enrollment;
- The start and end dates of your open-enrollment period; and
- Your contribution amount toward their employee premium.

You are responsible for notifying your eligible employees of the available health and dental plans offered through CCSB that are available in your rating region. It is important that you provide both the renewal sheets and the Employee Change Request Form to your employees during Open Enrollment. In addition, employees will not be able to make changes to their coverage after your annual open-enrollment period unless they experience a qualifying life event.

Did You Know?

Eligible employees may choose to enroll in a dental-only plan, even if they do not elect a health plan or if they have a valid waiver of coverage. A valid waiver would include health coverage through another employer, the military, Medicaid, Medicare or other federal or state health coverage programs other than coverage through a Qualified Health Plan (QHP) sold in the Individual Exchange.

You are also responsible as a health plan sponsor for providing certain health plan documents to your enrolled employees. This includes the Summary of Benefits and Coverage (SBC's) and health plan change summary documents available for your employees to use and reference. If an eligible employee declines or "waives" coverage, the employee must indicate they are declining coverage and state any other sources of coverage by completing and signing the Declination Acknowledgement on the Change Request Form for Employees.

For your convenience, these documents can be found at:

Plans

CoveredCA.com/ForSmallBusiness/Plans

Application

CoveredCA.com/ForSmallBusiness/Applications-

You should submit the Employer and Employee Change Request Forms using one of the following submission methods listed below:

To access the MyCCSB Portal: https://myccsb.com

Email:	CCSBeligibility@covered.ca.gov
Fax:	949-809-3264
U.S. Mail:	Covered California Small Business/CCSB P.O. Box 7010 Newport Beach, CA 92658

It is important that CCSB receive your health coverage changes no later than the 15th of the month prior to your plan year renewal date to ensure your employees receive new ID cards by the start of your plan year.
Changes received after that date may result in processing delays. Employees wishing to change carriers must do so prior to the renewal month. For faster processing, utilize the MyCCSB portal.

Plan changes submitted thru the 15th day of the renewal month will be effective retroactively to the 1st of the current month. CCSB will process plan changes submitted after the 15th day of the renewal month effective the 1st of the following month. **Note that plan changes made during the first 30 days of the renewal month must be within the same carrier.**

New Hire Enrollment

Employees added during the plan year are guaranteed coverage until the end of your plan year. A new hire is eligible for coverage the first day of the month after completion of your company's waiting period. You choose the waiting period that is right for your business, but the total waiting period cannot exceed 90 calendar days[1]. A newly eligible employee shall have a 30-day period to enroll in a qualified health plan beginning on the first day the employee becomes eligible.

After initial enrollment, plan changes submitted thru the 15th day of the first coverage month will be effective retroactively to the 1st of the current month unless otherwise requested. CCSB will process plan changes submitted after the 15th day of the first coverage month for the 1st of the following month. **Note that plan changes made during the first 30 days of coverage must be within the same carrier.**

1. Waiting Periods must comply with 42 U.S.C. Section 300gg-7 and applicable state law.

Deciding on a Waiting Period

The new hire waiting period for coverage cannot exceed 90 calendar days from the first day of your new hire's employment counting as day one. Since coverage begins on the first day of the month, you will want to choose a waiting period that is in compliance with the maximum 90-day timeframe:

For example, the following two scenarios would be in compliance:

- First of the month following 60 days from the date of hire;
- First of the month following the date of hire

When your employee is eligible to enroll in your CCSB health plan, new employees should complete and submit an Employee Change Request Form prior to effective date, but no later than within 30 days of the first day they become eligible. Employee Change Request Forms can be found at CoveredCA.com/ForSmallBusiness/Resources and should be submitted using one of the following submission methods below:

To access the MyCCSB Portal: https://myccsb.com

Email:	CCSBeligibility@covered.ca.gov
Fax:	949-809-3264
U.S. Mail:	Covered California Small Business/CCSB P.O. Box 7010 Newport Beach, CA 92658

It is our goal to enroll your employees with health insurance as quickly and effortlessly as possible. Generally, 10 calendar days are needed to process the change request forms provided the application information is complete. Application processing times include employer and employee eligibility verification. Submitting applications that are incomplete or have inconsistencies may delay processing times. Covered California will notify your employee of these inconsistencies and notification of an eligibility determination (See **Employee Eligibility & Verification** on pg. 8)

Qualifying Life Events – Special Open Enrollment Window

Employees and their dependents can enroll outside of open enrollment if they experience a qualifying life event. Qualifying life events allow employees, spouses and/or their dependent(s) to be eligible for health care benefits outside the annual open-enrollment period. If an employee waives coverage during Open Enrollment, they must either wait for the next annual open-enrollment period or have a qualifying life event in order to enroll in your group health coverage.

A list of qualifying events that would start a special enrollment period can be found in the following table. For more information on qualifying life events, please visit CoveredCA.com.

LIFE EVENT	TIME FRAME FOR APPLICATION	WHO CAN ENROLL?
Termination of Employment (ex-employee now eligible for a special enrollment as a dependent under a spouse's plan)	30 days from the last day of coverage	Employee (in this case, the employee is the still-employed spouse), spouse (who was terminated) and child dependents
Divorce, Legal Separation, or Loss of Dependent Status (dependent spouse or child loses coverage under subscriber's plan)	30 days from the last day of coverage	Employee plus dependents
Enrollee Loses a Dependent (spouse or child through death, divorce or legal separation)	30 days from the last day of coverage	Employee plus dependents
Death of the employee's spouse/registered or unregistered domestic partner (dependents lose coverage under deceased subscriber's plan)	30 days from the last day of coverage	Employee plus dependents
Reduction in Hours that led to ineligibility for benefits (makes the employee who lost eligibility, eligible for a special enrollment as a dependent under a spouse's plan)	30 days from the last day of coverage	Employee (in this case, the employee is the employed spouse), spouse (who lost eligibility) and child dependents
Qualified Health Plan Decertification	30 days from the last day of coverage	Employee plus all enrolled dependents
Loss of Pregnancy-related Coverage	30 days from the last day of coverage	Employee plus dependents
Loss of Medi-Cal Coverage	60 days from the last day of coverage	If employee loses, employee plus dependents. If dependent loses, dependent only.
Gains a Dependent (child, marriage, domestic partnership)	30 days from the event (marriage, domestic partnership decree, birth, adoption, foster care placement, QMSCO)	Employee plus all dependents (adult and child)
COBRA/Cal-COBRA Exhaustion (as opposed to termination for non-payment)	30 days from the last day of coverage	If employee exhausts, employee plus all dependents. If dependent exhausts, dependent only.
Erroneous Enrollment in a Qualified Health Plan	30 days from the last day of coverage in the wrong plan	Enrollee(s) who experience the error
Qualified Health Plan Misconduct	30 days from the last day of coverage in the QHP at issue	Employee plus all dependents

New Access to a Qualified Health Plan due to a permanent move, assuming that prior to the move, the enrollee had one or more days of MEC in the 60 days prior to the move, unless the enrollee was living outside of the US or was living in a US territory	30 days from the date the new access began	Employee plus all dependents
Loss of Access to a Qualified Health Plan because of a permanent move (moving out of an HMO service area)	30 days from the last day of coverage in the lost QHP	Employee plus all dependents
Released from Incarceration	30 days from the date of release	Employee plus all dependents
Returning from Active Duty	30 days from the date of return	Employee plus all dependents
An American Indian (allowed to change plans once per month, every month)	30 days advance notice for every month they want to make a change	Employee plus all dependents
Other Exceptional Circumstances on a case-by-case basis	30 days from the date of the event or last day of coverage, depending upon the circumstances. Consult with a CCSB representative.	Determined on case-by-case basis

TERMINATING COVERAGE

Terminating Your Small Business Coverage

To terminate health coverage for your company, you must provide written notice to CCSB prior to the end of the month in which coverage should end. For notifications received before the 15th of the month, terminations will become effective the end of the month in which it was received. Terminations received after the 15th of the month will become effective the end of the following month. Employees enrolled in a health plan will also receive notification from CCSB of discontinuation of health coverage within 15 days from the employer's written notice to CCSB. Such notification will provide information about other potential sources of coverage, including access to individual market coverage through the Exchange.

Terminating Coverage for an Employee or Dependent

To terminate coverage for an employee that has left employment or is ineligible, please complete the Employer Change Request Form. Termination requests must be received within the same calendar month as the requested termination date. If an employee would like to terminate their own coverage and/or the coverage of a dependent, the employee must complete the Change Request Form for Employees.

The coverage termination effective date for an employee and his/her dependents is based on the reason as outlined below:

TERMINATION REASON	TERMINATION EFFECTIVE DATE
Death	**The date of death.**
Termination of Employment	**The last day of the month in which eligibility changed.**
Ineligible	**The last day of the month in which eligibility changed.**
Employee Request	**The last day of the month in which an employee requests termination or a date in a subsequent month specified by the employee as long as the date is the last day of the month.**

An earlier effective date of termination may be determined on a case-by-case basis by CCSB and the QHP. However, the effective date of termination may be no other date other than the last day of the month. Employer and Employee Change Request Forms can be found at:

CoveredCA.com/ForSmallBusiness/Resources and should be submitted using one of the following submission methods below:

To access the MyCCSB Portal: https://myccsb.com

Email: CCSBeligibility@covered.ca.gov

Fax: 949-809-3264

U.S. Mail: Covered California Small Business/CCSB
P.O. Box 7010
Newport Beach, CA 92658

Please allow 5-7 business days for the processing of Employer or Employee Change Request Forms.

Change Forms upload into the MYCCSB Portal are typically processed within 2 business days. CCSB will mail the terminated employee or dependent a notice of termination. The former employee may be eligible for COBRA continuation coverage.

COBRA allows certain former employees and other participants such as retirees, spouses, former spouses, and dependent children the right to continuation of health coverage of your company's health plan rates. COBRA coverage, however, is only available when health coverage is lost due to a COBRA qualifying event.

COBRA HEALTH PLAN ADMINISTRATION

COBRA Health Plan Administration

The Consolidated Omnibus Budget Reconciliation Act (**COBRA**) offers employees and their dependents who lose their health benefits the opportunity to continue their coverage under your health benefit plan for limited periods of time. Under certain qualifying events such as voluntary or involuntary job loss for any reason other than gross misconduct, reduction in the hours worked, death, divorce, and other qualifying life events.

If a former employee elects to continue the group health insurance, the coverage given will be the same coverage that is currently available to active employees and their families as well as the same benefits, choices, and services such as:

- The rights to open enrollment to choose among available coverage options;
- The rights to add qualified beneficiary dependents;
- The rights to remove dependents voluntary; and
- The rights to remove dependents when they are no longer eligible for coverage

There are two types of COBRA offered. The type of COBRA that your company qualifies for is determined by the size of your company. CCSB administers Cal-COBRA benefits on your behalf whereas you are responsible to administer Federal Cobra Benefits.

Federal COBRA provides continuation of coverage for individuals under employer group health plans that have 20 or more employees. Federal COBRA is administered by the employer as a health plan sponsor or by a Third-Party Administrator (TPA) that you hire to perform this service for you. For more information on Federal COBRA coverage, please contact your TPA or visit *https://www.dol.gov/general/topic/health-plans/cobra*.

Note: You will receive a separate invoice for Federal COBRA participants, requiring a separate payment for these individuals.

Cal-COBRA provides continuation of coverage for individuals under employer group health plans that have 2 to 19 employees. Cal-COBRA is administered by CCSB on your behalf. CCSB may also administer the Cal-COBRA extension for coverage expiring under Federal COBRA.

COBRA TYPE	WHO QUALIFIES?	WHO ADMINISTERS?
Federal COBRA	Employers with 20 or more employees	Employer or an employer hired Third Party Administrator (TPA)
Cal-COBRA	Employers with 2-19 employees	CCSB

COBRA Qualified Beneficiaries

A qualified beneficiary is an individual who was covered by a group health plan on **the day a qualifying event occurred that caused him or her to lose coverage**. Only certain individuals can become qualified beneficiaries due to a qualifying event, and the type of qualifying event determines who can become a qualified beneficiary when it happens. A qualified beneficiary must be a covered employee, the employee's spouse or former spouse, or the employee's dependent child. In certain cases, involving the bankruptcy of the employer sponsoring the plan, a retired employee, the retired employee's spouse or former spouse, and the retired employee's dependent children may be

qualified beneficiaries. In addition, any child born to or placed for adoption with a covered employee during a period of continuation coverage is automatically considered a qualified beneficiary.

COBRA Qualifying Events

COBRA qualifying events cause an individual, whether an employee, spouse or dependent, to lose health coverage. The type of qualifying event determines the qualified beneficiaries and the amount of time that health coverage must be offered under COBRA. The following table below shows the specific qualifying events, the qualified beneficiaries who are entitled to continuation of coverage, and the maximum period of continuation of coverage that must be offered based on the type of qualifying event.

QUALIFYING EVENT	QUALIFIED BENEFICIARIES	FEDERAL COBRA LENGTH OF COVERAGE	CAL-COBRA LENGTH OF COVERAGE
Voluntary or involuntary termination of employment (for reasons other than gross misconduct or reduction of employment hours)	Employee Spouse Dependent Child	18 months	36 months*
Employee becomes entitled in Medicare	Spouse Dependent Child	36 months	36 months**
Divorce or legal separation	Spouse Dependent Child	36 months	36 months
Death of employee	Spouse Dependent Child	36 months	36 months
Loss of "dependent child" status	Dependent Child	36 months	36 months

*In certain circumstances, qualified beneficiaries entitled to the 18 months of continuation of coverage may become entitled to disability extension for an additional 11 months (for a total of 29 months) or an extension of 18 months (for a total of 36 months). The Social Security Administration (SSA) determines the qualified beneficiary before the 60th day of continuation of coverage which the qualifying event occurs.

**The continuation of coverage may vary due to when the employee becomes entitled to Medicare prior to or after the end of the covered employee's employment or reduction of hours of employment.

Events That Do Not Qualify for COBRA

Certain events may cause loss of coverage but do not qualify for COBRA continuation. These non-qualifying events include when an employee:

- Waives coverage
- Fails to elect within the 60-day timeframe to elect COBRA continuation coverage
- Voluntary removes their dependent's coverage
- Is terminated due to gross misconduct

Your Federal COBRA Notification Responsibilities

Under Federal COBRA, you must provide qualified beneficiaries and their families certain notices explaining their COBRA rights, how to elect COBRA, and when it can be terminated in a timely manner when they experience a loss of health coverage.

COBRA Election Notices

For Cal-COBRA (2 to 19 employees), CCSB will send all notifications to your terminated employees on your behalf.

If your employer group qualifies for Federal COBRA (20 or more employees), you or your hired TPA must send your former employee their Federal COBRA Notification & Rights with a Federal COBRA Election Form within 14 days of their health coverage termination. The purpose of this notification is to inform your employee of their COBRA qualifying status and the rules and regulations of the COBRA Continuation Coverage.

For more information on federal COBRA coverage, please visit *dol.gov/general/topic/health-plans/cobra*.

How Should I Process A Federal COBRA Election Form?

When you receive a Federal COBRA election form within the 60-day election period you are required to notify CCSB immediately of the election by submitting the COBRA Election Form via:

U.S. Mail

Covered California Small Business/CCSB
Attn: COBRA Dept.
P.O. Box 7010
Newport Beach, CA 92658

Email: CCSBcobra@covered.ca.gov

Fax: 949-809-3264

Depending on the arrangement that you have for your Federal COBRA administration if applicable, CCSB will work with you and/or your administrator to invoice and collect premium remittance. You are responsible for submitting the Federal COBRA premiums within CCSB guidelines and Federal COBRA laws.

Note: You will receive a separate invoice for Federal COBRA participants, requiring a separate payment for these individuals.

Employee Termination Notices

CCSB will administer termination of coverage notices for Cal-COBRA participants.

If your employer group qualifies for Federal COBRA, you are responsible for notifying a current COBRA participant directly when their COBRA health coverage has terminated.

The termination notice should be sent to the employee's last known address following:

- Failure to submit their premium payment on time
- Your termination of employee health coverage
- Your COBRA participant starting coverage with another group plan
- Your COBRA participant starting coverage with Medicare
- Your COBRA participant's request for termination

Employee COBRA Notifications

Your former employee or eligible dependents must notify you or CCSB, whichever is applicable, of their COBRA election within 60 days of their qualifying event. Failure to provide notification will result in their loss of health coverage continuation rights.

Federal and Cal-COBRA Coverage Payment

If a qualified beneficiary elects to continue health benefits within 60 days of their qualifying event, the initial premium payment must be made within 45 days of the COBRA election date. The beneficiary is responsible for the total cost of COBRA which will be 100% of the total contribution premium plus a 2% administration fee (Not to exceed 102% of the premium cost) for Federal COBRA group. The beneficiary is responsible for the total cost of COBRA which will be 100% of the total contribution premium plus a 10% administration fee (Not to exceed 110% of the premium cost) for Cal-COBRA group. Qualified beneficiaries receiving the additional 11 months disability extension will experience an increased premium up to 150% of the total premium cost during those 11 months. Any person or entity can pay COBRA contributions for a qualified beneficiary; however, it is the qualified beneficiaries' responsibility to ensure that payment is made in a timely manner.

All premium payments are due prior to the first day of the month of coverage. Participants have a 30-day grace period by which to remit premium. The payment must be postmarked by the 30th of the current month or coverage will be terminated with no reinstatement option.

COBRA Termination

Coverage begins on the date that a loss of other coverage occurred and will end at the end of the maximum COBRA period. Coverage may end earlier if premiums are not paid on a timely basis, if you choose not to maintain your group health plan, or your former employee obtains other coverage after COBRA is elected.

If your group qualifies for Federal COBRA, you must also send a termination notice to COBRA participant's last known address for any of the following termination reasons:

- Failure to pay premiums in full on a timely basis;
- The employer ceases to maintain group health coverage for employee;
- Participant begins coverage with another group plan;
- Participant becomes entitled to Medicare;
- Participant engages in health insurance misconduct or fraud; or
- Participant submits request for termination.

SMALL BUSINESS TAX CREDITS

Small Business Tax Credits

The Patient Protection and Affordable Care Act (ACA) offers access to federal tax credits that make providing employee health insurance more affordable. If qualified, you may be eligible for a federal tax credit that reimburses up to 50% of your employee premium contribution if you purchase coverage through CCSB.

The tax credit amount depends on several factors including the number of full-time employees and the amount contributed towards health insurance premiums. Generally, if you have fewer than 25 FTEs and pay an average annual salary of less than $54,000 per year (adjusted annually for inflation) you will be eligible for the tax credit. If you have fewer than 10 full-time equivalent employees with wages averaging less than $26,000 per year you will be eligible for the maximum tax credit amount. The maximum available tax credit is 50 percent of insurance premium expenses and is available for a total of two consecutive tax years. Tax credits are also available for qualifying nonprofit or tax-exempt employers. Non-profit or tax-exempt employers must meet the same eligibility criteria; however, their maximum tax credit amount is 35%.

To assist you in estimating the small business tax credit for your business, a tax credit calculator is available at https://www.coveredca.com/forsmallbusiness/taxcredit/. You can use this calculator to help determine if you qualify for the federal tax credit and to estimate your tax credit amount. CCSB also encourages you to visit IRS.gov and to contact your tax professional for additional information or assistance.

CONTACT COVERED CALIFORNIA SMALL BUSINESS

CCSB is committed to supporting your small business health insurance program. We invite you and your employees to contact us or your Certified Insurance Agent with any questions or concerns. You may also visit the CCSB website at https://www.coveredca.com/forsmallbusiness/ for access to additional resources that may be useful to you.

These online resources include:

- Tax Credit Calculator
- Resources for Participating Employers, including
  - Employer & Employee Change Request Forms
  - COBRA Forms & Notices
  - Appeal and Complaint Forms
  - Health & Dental Plan Resources
  - Contact Information
- Information about the Employer Mandate
- Latest News and Articles

If there are additional questions, or if you should need assistance with the application or enrollment process, please contact your Certified Insurance Agent or the CCSB Service Center at **(855) 777-6782** for assistance.

CCSB HEALTH & DENTAL INSURANCE COMPANIES

Health Insurance Companies

Blue Shield of California
http://www.blueshieldca.com
(855) 836-9705

Chinese Community Health Plan (CCHP)
www.cchphealthplan.com
(888) 775-7888

Health Net
www.healthnet.com
(877) 288-9082

Kaiser Permanente
www.kp.org
(800) 464-4000

Sharp Health Plan
www.sharphealthplan.com
(800) 359-2002

Oscar Health
https://www.hioscar.com/
(855) 672-2784

Dental Insurance Companies

California Dental Network
www.caldental.net
(877) 433-6825

Delta Dental of California
www.deltadentalins.com
DPPO: (800) 471-0287 DMHO:
(800) 471-7583

Dental Health Services
www.dentalhealthservices.com/CA
(855) 495-0905

Liberty Dental Plan
www.libertydentalplan.com/coveredca
(888) 844-3344

ADDITIONAL RESOURCES

Office of the Patient Advocate

Visit http://www.opa.ca.gov or by phone at **(866) 466-8900**.

This state agency provides a great overview of the health care industry, with a glossary of terms, patient rights, and a step-by-step guide that shows consumers how to deal with a problem or file a complaint against their health insurance company. This agency does not file complaints against health insurance providers, but it can tell consumers what state agencies can help.

California Department of Managed Health Care (DMHC)

Visit http://www.dmhc.ca.gov or by phone: **(888) 466-2219**.

This state agency oversees HMOs and some PPOs. Consumers can contact the DMHC if they've filed a complaint against their health insurance company because it denied coverage based on lack of medical necessity or if a treatment is being considered experimental or investigational in nature. This agency administers what's called an "*Independent Medical Review*."

If their situation qualifies, an independent physician will review the health insurance company's decision and has the power to overturn that decision. The IMR is a free service available to anyone in California enrolled in a managed care health plan. This agency has the power to file a *"standard complaint*" against a health insurance company about a coverage denial and can overturn the company's decision.

California Department of Insurance (CDI)

Visit http://www.insurance.ca.gov or by phone at **(800) 927-4357**.

This state agency handles complaints against PPOs and it functions just like the Department of Managed Health Care (DMHC). Consumers can file a complaint with the CDI against their PPO carrier if coverage was denied based on lack of medical necessity or if a treatment is being considered experimental or investigational in nature. This agency administers what is called an "*Independent Medical Review*" (IMR). If their situation qualifies, an independent physician will review the health insurance company's decision and has the power to overturn that decision. The IMR is a free service available to anyone in California enrolled in a managed care health plan. This agency has the power to file a "standard complaint" against a health insurance company about a coverage denial and can overturn the company's decision.