COVERED CALIFORNIA FOR SMALL BUSINESS EMPLOYER GUIDE

COVERED CALIFORNIA™

FOR **SMALL BUSINESS**

WELCOME TO COVERED CALIFORNIA FOR SMALL BUSINESS

Covered California for Small Business is a part of California's State Health Benefit Exchange where employers with 100 or fewer full-time equivalent employees 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 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 the budget you can afford.

We're here to help! Covered California for Small Business 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 Covered California for Small Business website at *CoveredCA.com/ForSmallBusiness* for a number of additional resources that may be useful to you.

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Your Health Plan Responsibilities

While Covered California for Small Business 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 Covered California's small business program:

1. Knowing Your Full-Time Equivalent (FTE) Employee Count and Applicable Large Employer Status
2. Meeting Covered California's 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 Covered CA with Notices of Eligibility Changes
9. Notifying Employees of Open Enrollment
10. 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 health insurance 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, small businesses and their employees are required to reveal confidential information. Protecting this information is of utmost importance to Covered California for Small Business. Any information collected on a Covered California for Small Business 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 Covered California for Small Business, you must have 100 or fewer full-time equivalent employees. You must also have:

- A principal business address in California
- At least one employee who receives a W-2
- Elected to offer CCSB coverage to all eligible employees
- Agreed to the employee participation rate requirement
- Agreed 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 full-time equivalent (FTE) employees are eligible to enroll in Covered California for Small Business. Calculating your total FTE employee 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 FTE employee count, we encourage you to visit the *IRS.gov/ACA* website and review the IRS-related Affordable Care Act resources available for employers on this topic.

Although your total FTE count determines your business' eligibility to participate in Covered California for Small Business, it's important to note that not every employee may be eligible for coverage (See **Employee Eligibility & Verification** on pg.7).

Did You Know?

If your full-time equivalent or FTE employee count should increase beyond 100 throughout your plan year, you will continue to remain eligible for Covered California for Small Business provided other eligibility standards are met. Should you elect to terminate your health coverage with Covered California but want to re-apply at a later time, know that you may no longer be eligible to participate if your FTE employee count has exceeded 100 employees.

Knowing Your Small and/or Applicable Large Employer Status

Applicable Large Employers

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

The mandate requires that employers with 50 or more full-time equivalent employees offer health coverage that is both "affordable" and that meets a "minimum value" to their 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 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.

Employers that have less than 50 employees are considered a small business by the ACA, and while encouraged to offer health coverage are not required to do so by law. Nevertheless, employers that offer health coverage, regardless of whether they are small or large, may find that it helps them to attract top talent and improve productivity at their place of 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 option for employees.

Offering coverage through Covered California for Small Business 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 full-time equivalent employees. Historically, small group size in the health insurance industry was determined for employers that had up to 50 full-time employees. With the recent expansion, employers with 51-100 FTE employees are now also considered small group. Covered California for Small Business changed its eligibility requirements to align with the state expansion of small group, which means that employers with up to **100 FTE employees** 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 Applicable Large Employer (those groups with 50 or more FTEs), as defined by the Affordable Care Act, 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 Covered California's small business program but also required to offer health coverage as an ALE.*

EMPLOYER ELIGIBILITY GUIDELINES

COVERED CALIFORNIA | FOR SMALL BUSINESS

Employer Contribution Requirement

Employers that are eligible to participate in Covered California for Small Business are required to contribute at least 50% of the cost towards the lowest health plan 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.

Employee Participation Rate Requirement

When offering coverage through Covered California for Small Business, at least 70% of your eligible employees must be able to enroll in an offered health plan. Further, if you elect to contribute 100% to your employees' health insurance premiums or have just one to three eligible employees, then all eligible employees must enroll in CCSB health coverage in order for your business to be eligible for the small business program.

An eligible employee who waives coverage due to enrollment with another employer or has coverage through a union, the military, Medicaid or Medicare is not counted against your total employee participation rate.

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.

Employers can enroll in Covered California for Small Business at any time throughout the year, but excluding the Annual Special Enrollment Period, employers must have at least 70% of their employees enroll in a health plan and contribute at least 50% of the cost towards their employees' premiums.

> **Did You Know?**
> *During a limited time each year, from November 15 to December 15, Covered California for Small Business allows employers that have not met its minimum participation rate and/or premium contribution requirements to enroll for health coverage. Business owners can enroll in the small business program even if only a few employees accept the coverage or they cannot afford to meet the premium contribution requirement.*

Offering Infertility Coverage

Infertility coverage is an elective benefit that employers can choose to offer as part of their health plan program. However, employers with 20 or more full-time equivalent (FTE) employees who choose to offer infertility benefits, must offer all of their employees with health plans that include infertility as a covered benefit. The opposite is true for employers of this size that do not offer infertility coverage. Employees cannot access health plans with infertility benefits if the employer does not offer this coverage.

For employers with less than 20 FTEs who offer infertility benefits, know that employees must select either a PPO or EPO plan; the HMO plans with infertility are not available for employers of this size. Employees cannot access health plans with infertility benefits if the employer does not offer this coverage.

Employer Eligibility & Verification

Covered California for Small Business 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 take action 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 Covered California for Small Business 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.

Covered California for Small Business 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 written notice to the employee. Your employee will have 30 days from the date of the notice to resolve the inconsistency. If the employee does not take action within that 30-day period, we will provide written notice to them about their denial of eligibility to enroll in the program.

Your employee may voluntarily elect to waive your offer of coverage. An eligible employee who waives coverage due to enrollment with another employer or has coverage through a union, the military, Medicaid or Medicare would not be counted against your total employee participation rate. An employee that waives their offer of coverage is not eligible to enroll in your health plan until your next open enrollment.

Dependent Eligibility & Verification

Should you elect to offer dependent coverage, enrollees and their dependents must enroll in the same health and dental plan. Dependents that qualify and are eligible for health coverage through Covered California for Small Business must be under the age of 26.[1] This includes adopted children, foster children or those under legal guardianship. Disabled adult children (regardless of age) are also considered qualified dependents. Eligible dependents may be added during the plan year if they experience a qualifying life event or during your annual open-enrollment period.[2]

Did You Know?

Spouses and domestic partners are not considered "qualified 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 registered and non-registered domestic partners but it is not required when electing to offer dependent coverage.

Employers can elect to offer employee only-coverage. In the event that 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 to your employee if there are inconsistencies between your company and employee applications. Your employee will have 30 days from the date of the notice to resolve the inconsistency on behalf of their dependent. If they do not take action 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

1. Dependents that are eligible for dental coverage must be the under the age of 19.
2. Dependents that reside out of state are eligible for emergency coverage only unless on an eligible PPO plan. Note that only certain PPO plans offer coverage outside of California.

Eligibility Appeal Process

If you or your employees receive a denial of eligibility or do not receive timely notification of eligibility from Covered California for Small Business, 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, Covered California 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 Covered California for Small Business Service Center at (855) 777-6782.

Reporting a Change to Your Business

A number of 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 Covered California for Small Business 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 Health Plan Premiums** on pg. 12). However, Covered California for Small Business 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 Covered California for Small Business. Employer Change Request Forms can be found at CoveredCA.com/ForSmallBusiness/Resources and should be submitted using one of the following methods below:

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

Fax
949-809-3264

Please allow 30 days for your business change to be updated in our system and on your monthly invoice.

Reporting a Change in Employee/ Dependent Eligibility

As a health plan sponsor, you are required to report any changes in your employees' eligibility to Covered California for Small Business. 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. Employee Change Request Forms can be found at CoveredCA.com/ForSmallBusiness/Resources in both English & Spanish. Forms should be submitted to Covered California for Small Business using one of the following methods below:

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

Fax
949-809-3264

Please allow 30 days 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 Covered California for Small Business, you or your employees can only make changes to health coverage during your annual election and open-enrollment period. Modifications that can be made during this time include changes to your:

- Selected 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
- New hire waiting periods
- Number hours of work necessary for coverage
- Total change in number of FTEs
- Dependent coverage
- Infertility coverage

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

Your employees can make changes to health coverage throughout your plan year should they experience a qualifying event, such as becoming a newly hired employee or a new parent. Read on for more information on what changes can be made during these time periods (see **Qualifying Life Events – Special Enrollment** on pg. 16).

YOUR PREMIUMS & PAYMENT FOR HEALTH COVERAGE

Your Health Plan 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. In circumstances where an employee lives out of your rating region and has access to a regional health insurance company that is not available in your rating area, Covered California will allow that employee to enroll in a regional health plan if selected. In this case, the employee's residential zip code may be used to enroll the employee and generate premium rates for the regional plan.

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 Health Premium Payments

Although employees can choose from multiple health insurance plans, you pay Covered California directly with one single payment for all eligible employees for the covered month. It is important you send in your full payment by the first of the month as your Covered California for Small Business coverage will not take effect until payment is received. Failure to send in prompt payment may also 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. Covered California for Small Business 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** and must be postmarked by the last day of the invoicing month.

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 by the last day of the invoicing month, Covered California for Small Business will mail a notice of delinquency on the day after payment is due explaining the terms of a 30-day grace period. Note that you will receive a different invoice for your COBRA participants, requiring a separate payment for these individuals.

Grace Period

A period of 30 days will be allowed for payment of any premium due after the initial premium. If full premium due 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.

Should your coverage be terminated for non-payment, you must submit a new application to Covered California for Small Business to obtain coverage for your employees.

Premium payments should be sent to the following billing address:

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

Covered California for Small Business will apply a $25 return fee for any of the accepted payment methods that result in insufficient funds. Any enrollment or eligibility changes made and not reflected on your monthly invoice will be made on your following month's invoice.

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. Covered California for Small Business 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 changes to your health coverage (See **Making Changes to Your Health Coverage** pg. 11). The election period for you to make changes to your offer of coverage is at least 10 calendar days in length, beginning on the day that Covered California for Small Business 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 for your upcoming plan year. They may also add and terminate eligible dependents.

Open Enrollment Notifications

At the start of your annual open-enrollment period, Covered California for Small Business 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 current premium rates. The renewal packet will also include both an Employer and Employee Change Request Form that you and your employees can 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. 18) participants of:

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

You are responsible for notifying your eligible employees of the availability of health and dental plans offered through Covered California for Small Business and 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, it is important to emphasize that unless an employee experiences a qualifying event, employees will not be able to make changes to their coverage after your annual open-enrollment period.

> **Did You Know?**
> *Eligible employees may choose to enroll in a dental-only plan, even if they do not elect a health plan, if they have a valid waiver of coverage. A valid waiver would include health coverage through another employer, a union, the military, Medicaid or Medicare.*

You are also responsible as a health plan sponsor for providing certain health plan documents to your enrolled employees. This includes making Summary of Benefits and Coverage, and health plan change summary documents available for your employees to use and reference. For your convenience, Covered California for Small Business has posted these important documents to our website and can be found at CoveredCA.com/ForSmallBusiness/Plans.

Open Enrollment Notifications

(continued)

Employer and Employee Change Request Forms should be submitted to Covered California for Small Business using one of the following submission methods below:

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

Fax
949-809-3264

It is important that Covered California 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.

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[3]. Please note that at CCSB waiting periods are calculated on the date the employee becomes a qualified employee who is otherwise eligible for coverage, regardless of when you notify CCSB about a newly qualified employee.

3. Waiting Periods must be in compliance with Section 10198.7(c) the California Insurance Code and the Section 13575.1(c) California Health and Safety Code

Deciding on a Waiting Period

The waiting period for coverage cannot exceed 90 calendar days starting with 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 time frame:

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 Covered California for Small Business health plan, use the Employer Change Request Form to add them to your employee roster. This will allow your new hire to begin the open-enrollment process. New employees should complete and submit an Employee Change Request Form. Your New Hire will have 30 days to enroll starting with the first day they become eligible.

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:

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

Fax
949-809-3264

It is our aim to connect your employees with health insurance as quickly and easily as possible. Generally, 10 calendar days are needed to process the change request forms for both you and your new employee 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. 7).

Qualifying Life Events – Special Enrollment Period

Coverage for employees and their dependents can be added, changed or removed outside of Open Enrollment but only if a "Qualifying Life Event" occurs. Qualifying life events allow an employee, spouse and/or dependent 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 event in order to be eligible for 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 events, please visit CoveredCA.com.

LIFE EVENT	TIMEFRAME 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 dead 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 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 Program.	Determined on case-by-case basis

Terminating Your Small Business Coverage

To terminate health coverage for your company, you must provide written notice to Covered California for Small Business at least thirty (30) calendar days prior to the end of the month in which coverage should end.

Terminating Coverage for an Employee or Dependent

To terminate coverage for an employee or dependent, submit the termination request using an Employee Change Request Form.

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.**
Did Not Apply for Coverage During Open Enrollment	**The last day of the current plan year.**

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:

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

Fax
949-809-3264

Generally, 10 calendar days are needed to process information on an Employer or Employee Change Request Form. Covered California for Small Business 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 at your company's health plan rates. COBRA coverage, however, is only available when regular health coverage is lost due to a COBRA qualifying event.

COBRA Health Plan Administration

The Consolidated Omnibus Budget Reconciliation Act (**COBRA**) offers employees and their dependents the opportunity to continue their employer's health benefit plan for limited periods of time in the event they should lose coverage because of a COBRA qualifying event.

As a health plan sponsor, you can offer the employee losing coverage a contract that allows the formerly covered employee and qualifying beneficiaries to continue coverage in the group health plan.

If the former employee elects to continue the group health insurance, they have access to the same coverage as all other active employees. This also includes the same rights and responsibilities as all other covered employees and dependents.

These rights and responsibilities include:

- The right to participate in Open Enrollment;
- The right to add qualified beneficiary dependents;
- The right to remove dependents voluntarily
- The responsibility to remove dependents when they are no longer eligible for coverage.

There are two types of COBRA processes and are based on your company size. Covered California for Small Business only administers Cal-COBRA benefits on behalf of the employer group:

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 *dol.gov/general/topic/health-plans/cobra*.

Cal-COBRA provides continuation of coverage for individuals under employer group health plans that have 2 to 19 employees. Cal-COBRA is administered by Covered California for Small Business on your behalf. Covered California for Small Business 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
Cal-COBRA	Employers with 2-19 employees	CCSB

COBRA Qualified Beneficiaries

A qualified beneficiary is an individual covered by a group plan on the day before 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. An employer's agents, independent contractors, and directors who participate in the group health plan may also be qualified beneficiaries.

COBRA Qualifying Events

COBRA qualifying events are certain events that cause an individual, whether an employee, spouse or dependent, to lose health coverage. The type of qualifying event determines who the qualified beneficiaries are and the amount of time that you must offer health coverage to them under COBRA. The below tables provide the qualifying events for qualified beneficiaries, including employees, spouses and dependents.

COBRA Qualifying Events for **EMPLOYEES**:

LIFE EVENT	FEDERAL COBRA LENGTH OF COVERAGE	CAL-COBRA LENGTH OF COVERAGE
Voluntary or involuntary termination of employment for reasons other than gross misconduct	18 months	36 months
Reduction in the number of hours of employment	18 months	36 months
Disability determination by Social Security Administration	29 months	36 months

COBRA Qualifying Events for **SPOUSES**:

LIFE EVENT	FEDERAL COBRA LENGTH OF COVERAGE	CAL-COBRA LENGTH OF COVERAGE
Voluntary or involuntary termination of employment for reasons other than gross misconduct	18 months	36 months
Reduction in the number of hours of employment	18 months	36 months
Covered employee now eligible for Medicare	36 months	36 months
Divorce or legal separation from the covered employee	36 months	36 months
Death of the covered employee	36 months	36 months

COBRA Qualifying Events for **DEPENDENTS** are the same as for Spouses with one addition:

LIFE EVENT	FEDERAL COBRA LENGTH OF COVERAGE	CAL-COBRA LENGTH OF COVERAGE
Loss of dependent child status	36 months	36 months

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

Your COBRA Notification Responsibilities

As a business owner, your employees and eligible dependents must receive a notification of COBRA coverage options in a timely manner when they experience a loss of health coverage that is also a COBRA qualifying event.

COBRA Election Notices

For employers that qualify for Cal-COBRA (2 to 19 employees), Covered California for Small Business will send all notifications to your terminated employees on your behalf.

For employers that qualify 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 30 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.

Notifications should be sent to an employee's last known address within 14 days following:

- Termination of employment (voluntary or involuntary)
- Reduction in work hours
- Entitlement to Medicare
- Death
- Divorce or legal separation
- Loss of dependent child status

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 and the premium payment to bring the account current, notify Covered California for Small Business immediately of the election by submitting the COBRA Election Form via:

U.S. Mail
Covered California for Small Business
Attn: COBRA Dept.
P.O. Box 7010
Newport Beach, CA 92658

Fax
949-809-3264

Depending on the arrangement that you have for your Federal COBRA administration if applicable, Covered California for Small Business will work with you and/or your administrator to invoice and collect premium remittance.

COBRA Termination Notices

CCSB will administer termination of coverage notices for Cal-COBRA participants. Employers that qualify for Federal COBRA are responsible for notifying a current COBRA participant directly when their 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 Covered California for Small Business, 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.

COBRA Coverage Payment

If a qualified beneficiary elects to continue health benefits, the beneficiary is responsible for the full (100%) premium contribution for COBRA health coverage. A 2% administration charge may also be applied by the employer group. 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 contributions are due prior to the first 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, you choose not to maintain your group health plan, or your former employee obtains other coverage after COBRA is elected.

Employers that qualify for Federal COBRA must also send a termination notice to COBRA participant's last known address for any of the following termination reasons:

- Failure to submit contribution on time
- You no longer provide coverage for employees
- Participant becomes covered by another group plan
- Participant becomes covered by Medicare
- Participant submits request for termination

Small Business Tax Credits

The Patient Protection and Affordable Care Act (ACA) offers eligible small business owners access to federal tax credits that make providing employee health insurance more affordable. Small businesses may qualify for a federal tax credit that reimburses up to 50 percent of their employee premium contribution if they purchase coverage through Covered California for Small Business.

The tax credit amount depends on a number of factors including the number of full-time employees and the amount contributed towards health insurance premiums. Generally, small businesses that have fewer than 25 full-time equivalent employees and pay an average annual salary of less than $52,000 a year will be eligible for the tax credit for up to two years. Employers with fewer than 10 full-time equivalent employees with wages averaging less than $25,000 per year will be eligible for the maximum tax credit amount. Tax credits are also available for qualifying nonprofit or tax-exempt employers. Nonprofit or tax-exempt employers must meet the same eligibility criteria; however, their maximum tax credit amount will be somewhat lower.

To assist you in estimating the small business tax credit for your business, a tax credit calculator is available at *CoveredCA.com/ForSmallBusiness*. You can use this calculator to help determine if you qualify for the federal tax credit and to estimate your tax credit amount. Covered California also encourages you to visit IRS.gov and to contact your tax professional for additional information or assistance.

CONTACT COVERED CALIFORNIA FOR SMALL BUSINESS

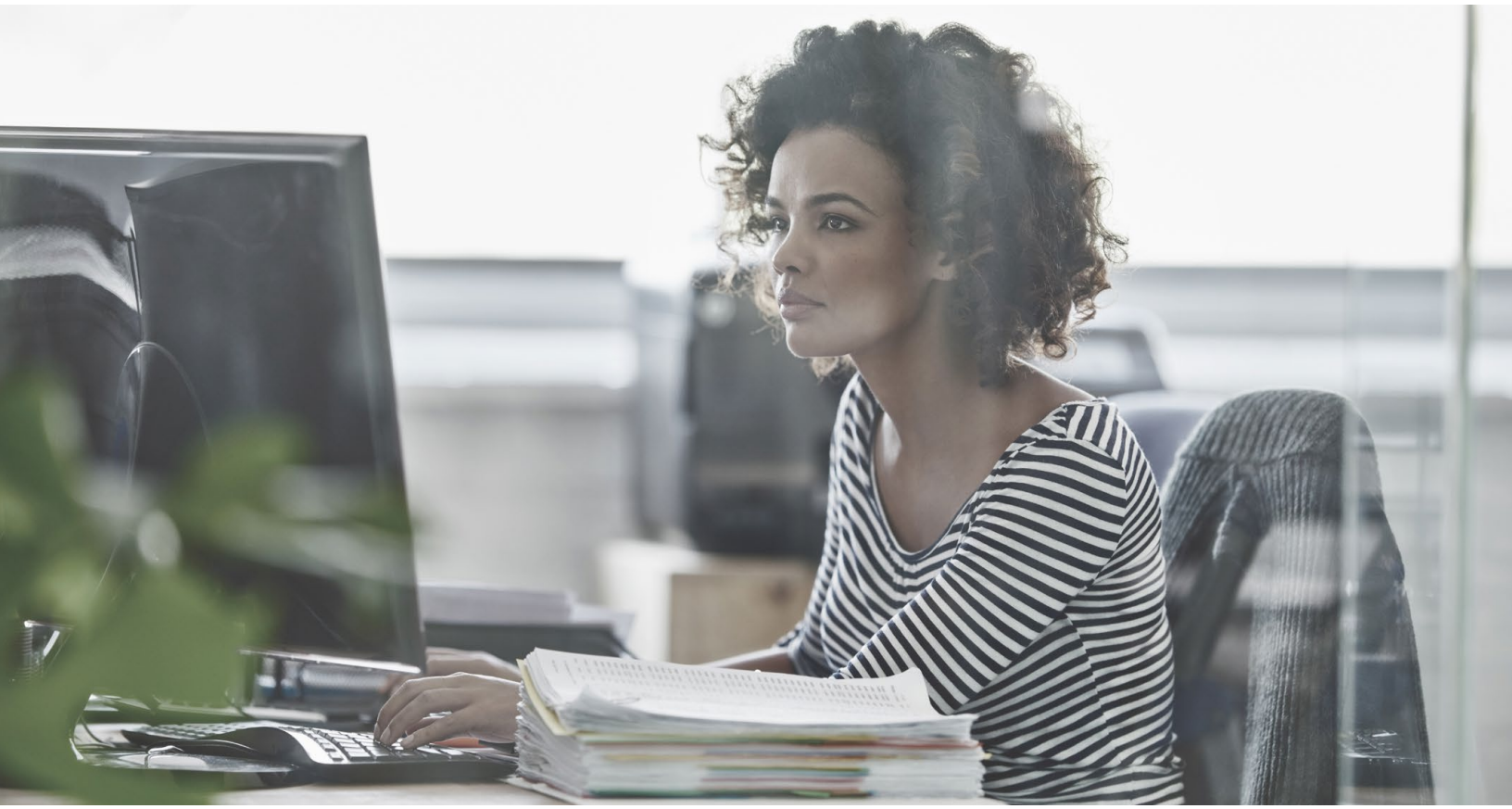
Contact CCSB

Covered California for Small Business is committed to supporting your small business health insurance program, and invites you and your employees to contact us or your Certified Insurance Agent with any questions or concerns. You may also visit the Covered California for Small Business website at *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
- Locate a Certified Insurance Agent

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 Covered California for Small Business' Service Center at (855) 777-6782 for assistance.



CCSB HEALTH & DENTAL INSURANCE COMPANIES

Health Insurance Companies

Blue Shield of California
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

Western Health Advantage
www.westernhealth.com
(888) 563-2250

Dental Insurance Companies

Access Dental Plan
www.premierlife.com
(877) 702-8800

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

Premier Access
www.premierlife.com
(877) 702-8800

Office of the Patient Advocate

Visit 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 (DHMC)

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

This state agency oversees HMOs and some PPOs. Consumers can contact the DMCH if they've filed a complaint against their health insurance company because it denied coverage based on lack of medical necessity or a treatment 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 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. Consumers can file a complaint with the CDI against their PPO if coverage was denied based on lack of medical necessity or if a treatment being considered experimental or investigational in nature. This agency administers what's 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.

Covered California and the **Department of Health Care Services** work together to support health insurance shoppers to get the coverage and care that's right for them.

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