COVERED CALIFORNIA FOR SMALL BUSINESS EMPLOYER GUIDE

COVERED CALIFORNIA
SMALL BUSINESS

Rev 03.07.2022

WELCOME TO COVERED CALIFORNIA FOR SMALL BUSINESS

Covered California for Small Business (CCSB) is a part of California's Health Benefit Exchange where employers with 100 or fewer Full-Time Equivalent Employees (FTEs) can access brand name health insurance plans 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. CCSB is the only place in California where small businesses can qualify for the federal health care tax credit.

We provide you with clearly defined tiers of coverage—Platinum, Gold, Silver, and Bronze. We offer more choices to your employees with up to all four metal-tiers. For example, you can set your budget on the silver tier but allow employees to choose from any available plans that may fit their lifestyle.

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, 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!

The MyCCSB portal offers easy web-based access to all your group enrollment and account information. Best of all, this paperless function provides fast processing. Use the portal to perform essential functions such as renewal changes, accessing your invoices, making online payments, managing your employees, and viewing your current balance at your convenience.

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 Additions 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 "***Create an Employer Account***" button.
2. Enter the required information: Username, Email, Password, Federal Employer Identification Number (FEIN), First & Last Name, Primary Phone Number & Type,
3. Click the "***Create Account***" button.
4. You will receive a follow up email and will confirm your account by clicking the provided link.

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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 employer sponsored health coverage through the CCSB program:

1. Knowing Your Full Time Equivalent (FTE) Employees Count and Applicable Large Employer Status
2. Meeting CCSB Eligibility Requirements
3. Determining Your Metal Tier 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 from 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 laws and 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 include:

- Employer's principal business address must be in California or employer offers 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 employees
- Employer must comply with the employee participation requirement
- The majority of employees are employed within California
- Employer must contribute at least 50 percent of the lowest cost employee-only plan in your selected metal tier of 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 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 is reviewed when determining 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 in the United States in 2010. The ACA requires employers of a certain size (50 or more FTEs) to offer health benefit 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 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 offering health coverage will help to attract top talent and improve productivity for your business. Providing employees with health coverage can increase morale and help with a company's retention, attracting 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 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 expansion, employers with 51- 100 FTEs are also considered a "small group". CCSB changed its eligibility requirements to align with the state expansion of small group, meaning 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 under California 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 & Reference Plan

Employer Contribution

If you are eligible to participate in CCSB, you must contribute at least 50% of the premium cost of the lowest premium available for employee-only coverage. This means that you must pay for at least 50% of the employee-only premium of the reference plan that you choose. You may select a reference plan on any metal tier, 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 metal tier(s) and the plan(s) your employee selects. There is no minimum dependent contribution requirement.

Employer Reference Plan

The reference plan is the plan you choose to determine the amount you will contribute toward your employee premium. This plan is selected yearly at your annual renewal period. 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, which determines your contribution cost, shall be the lowest cost plan that is the same metal tier as the previous plan. The contribution percentage amount for your employee's will remain the same as previously elected.

Employee Participation Rate Requirement

When offering coverage through CCSB, at least 70% of your eligible employees must enroll with CCSB. Employees with the following coverage are not included in the employee participation calculation:

- Employer Sponsored Coverage
- Military coverage
- Medi-Cal
- Medicare

  Any other federal or state health coverage program or any health coverage meeting the definition of minimum essential coverage

Annual Special Enrollment Period

You can enroll in CCSB at any time throughout the year, but 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. If you fail to meet the or minimum employee participation rate requirements, CCSB offers an Annual Special Enrollment Period every year from November 15 to December 15 when employers that meet all other eligibility guidelines are allowed to enroll for health coverage starting January 1.

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 eligible employees:

- For employers with 20 or more eligible employees who choose to offer Infertility benefits to their employees, all products shall include Infertility benefits.
- For employers with 20 or more eligible employees who choose to not offer Infertility benefits to their employees, no product shall include Infertility benefits.

Employers with less than 20 eligible employees:

- Employers with less than 20 eligible employees have the option to include Infertility benefits only on non-HMO plans.

Offering Dental Coverage

Employers and their employees have expanded opportunities for improved dental health coverage through CCSB family dental plan, stand-alone dental plan and dependent dental plan. Dental plan coverage is an elective benefit that you can choose to offer as part of your health plan program. If you choose to offer dental coverage to your employees then you must select a Dental Reference Plan, allowing you to choose how much you want to contribute to your employee's dental premiums. There is no minimum contribution requirement.

Optional Family Dental Plans:

- Employers can choose to offer dental benefits at an additional cost to the employees. You have the option to contribute to your employee(s) dental premium to help offset the employees' cost.
- Family dental plans offer coverage for both Employee(s) and their family. Employee(s) can choose to enroll in a family plan without enrolling the entire family.

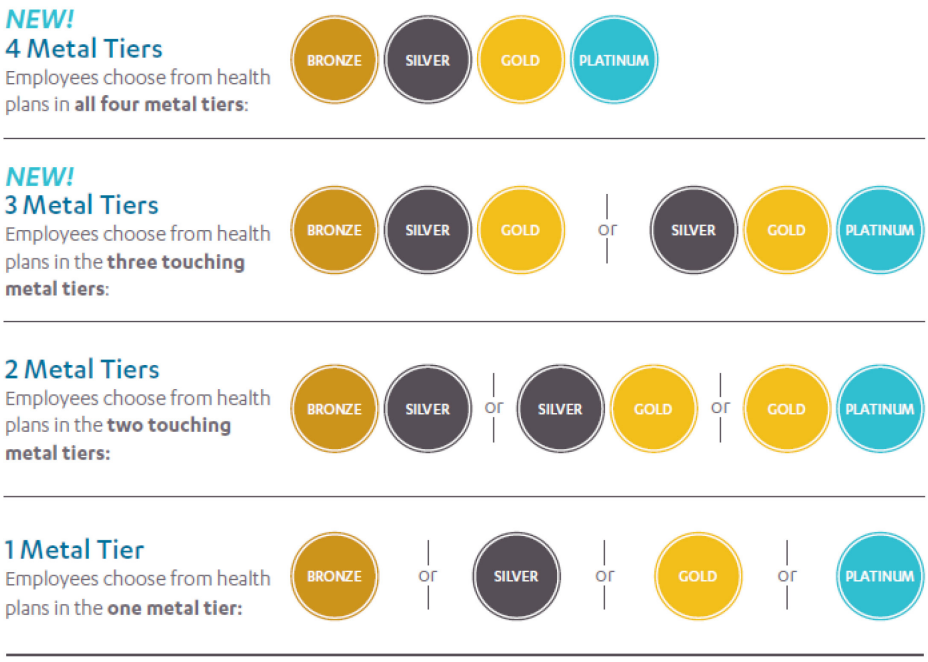
Optional Stand Alone Pediatric Dental:

- Pediatric Dental Plan is for children up to 19 years of age.

Note: *Many of the Qualified Health Plans offer pediatric dental benefits as part of their health plan coverage. Please refer to the health plan's Summary of Benefits and Coverage (SBC) or the Explanation of Coverage (EOC) for more information.*

Metal Tier Health Plans

Covered California for Small Business offers four tiers of coverage – Bronze, Silver, Gold, and Platinum. Employers have the option to choose to offer plans in a single metal tier, or up to all four metal tiers –The result is greater employee choice at no additional cost. This provides your employees with a choice of multiple health plan options, allowing them to find one that fits their needs and budget.



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 have 30 days to resolve any eligibility issues.

Employee Eligibility & Verification

Employees are eligible to participate in CCSB if you offer them coverage. 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. To be counted in your participation rate calculation, part-time employees must be permanent employees who 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, or temporary.

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 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 during a special enrollment period triggered by a qualifying event.

Dependent Eligibility & Verification

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 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 standalone pediatric 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 Family 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're an ALE and choose to offer employee only coverage, you may be subject to the Employer Shared Responsibility Provision.

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 be eligible to receive financial assistance through the Covered California Individual Marketplace.

For more information regarding the Employer Shared Responsibility Provision go to https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions.

In verifying eligibility for your employee's dependents, we will provide written notice if there are inconsistencies between your company and employee applications. You 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.

To request for an appeal: https://www.cdss.ca.gov/inforesources/state-hearings

Appeals must be submitted in one of the following ways:

1. **Delivered in-person or mailed to:**
   California Department of Social Services (CDSS)
   ATTN: ACA Bureau
   P.O. Box 944243
   Mail Station 21-97
   Sacramento, CA 94244-2430

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

3. **Phone:** (800) 743-8525

4. **Or by fax to:** (833) 281-0905

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 changes, know that it may affect premium rates and/or plan options for both you and your employees (see **Your Premiums & Payments** on pg. 15-16). Address changes will be updated effective first of the following month after receipt. However, if the address change impacts the rates, the rate change will go into effect upon renewal of coverage.

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 of the event. 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 for Small Business/CCSB
P.O. Box 7010
Newport Beach, CA 92658

For additional Language Line Assistance

For any enrollment changes or requests please allow one to two billing cycles for your employee(s) and/or their dependents to reflect on your invoice. With MyCCSB.com, you can quickly update and view your account online. NEW expanded functionality incudes:

- Complete your Renewal faster on MyCCSB.com
- Submit and confirm Employee(s) and/or Dependent(s) Enrollments, Terminations and Changes
- Save time on paperwork by inviting employees to submit their enrollment applications online
- View your real-time account balances and confirm payment receipt online
- Enroll in autopay for added convenience
- Experience quicker processing online*

*compared to traditional methods such as fax or paper submissions

Making Changes to Your Employer Application

You can only make changes to health coverage during your annual election and open-enrollment period. Changes made during this time may include the following:

- Metal Tier Selection (Bronze, Silver, Gold, Platinum) provides the option to choose up to four contiguous metal tiers of coverage
- Reference Plan
- Contribution percentage
- Update number of FTEs
- Dependent coverage
- Dental coverage
- Infertility coverage

Making Changes to Employee Applications

After enrollment, eligible employees can change their selected health plan during the first 30 days of the new plan year if 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.

If at renewal an employee's plan is discontinued, the employee 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.

If an employee experiences a qualifying life event, they may be eligible to make changes to their health coverage. 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 premium rates are guaranteed for 12 months from your initial coverage effective date. Your business address determines the cost of premiums that you pay for your health plan. Your address will fall in one of the 19 rating areas in California that determine the amount of financial adjustments made to your health insurance premiums.

Making Premium Payments

Initial Payment

Although employees can choose from multiple health plans, CCSB will send you a single invoice accounting for all health plans. CCSB must receive payment for the total amount billed by the due date of the invoice. Until payment is received employees are not covered. Failure to send in prompt payment will delay your effective date or require you to resubmit your enrollment materials.

Ongoing Payments

The billing cycle starts the 1st of each month. CCSB will send you an invoice on or about the 15th of each month for your employees' premiums for the upcoming month of coverage. Payment must be delivered to CCSB or postmarked by the last day of the invoicing month. On-going monthly premium payments must be made for the total balance due, by the due date on the invoice to avoid delinquency or cancellation.

You are expected to pay the total balance owed. Failure to submit full payment of the invoice balance due will result in delinquency or cancellation of your coverage. If the full amount is not paid or postmarked by the due date indicated on the invoice, CCSB will mail a Notice of Start of Grace Period on the day after payment is due explaining the terms of a 30-day grace period. The Notice of Start of Grace Period will include instructions for making the required payment to maintain coverage and your rights to request review of the cancelation by an applicable regulator.

If coverage is terminated due to non-payment, you will be notified of the reason and a Notice of End of Coverage. If you are terminated for non-payment, you may request to be reinstated in the same coverage in which you were last enrolled. Requests for reinstatements must occur within 30 days after the effective date of termination and all past due payments must be made prior to reinstatement. You can only be reinstated once in a 12-month period. If you request reinstatement 31 or more days following the effective date of the termination, you must reapply for a new group policy.

Grace Period

An employer group will receive a Grace Period of 30 days to remit payment for all past due balances. If full premium is not received before the expiration of the 30-day grace period, coverage will be terminated. A Notice of End of Coverage will be sent after the after termination. Pursuant to California's State Accounting Manual's collection policies, CCSB will send three collection letters for outstanding payments at 30-day intervals. If a response not made within 30 days of the third letter, CCSB will pursue other collection methods including 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 for 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 payment resulting 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.

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 or contribution changes to your health coverage (See **Making Changes to Your Health Coverage**). After CCSB sends you notice of your annual election period, you have at least 20 days to change your offerings

Once you have made your health coverage changes, 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. 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 include both an Employer and Employee Change Request Form required to make changes to coverage.

Once you receive a renewal packet from CCSB, it is your responsibility to notify your eligible employees and any Federal COBRA (see **COBRA Health Plan Administration** on pg. 22) qualified beneficiaries 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 health and dental plans available to them through CCSB. It is important that you provide both the renewal sheets and the Employee Change Request Form to your employees during Open Enrollment. 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 plan, without electing a health plan through CCSB.

You are also responsible for providing the Summary of Benefits and Coverage (SBC's) and health plan change summary documents to your employees to use and reference. If an eligible employee declines or "waives" coverage, the employee must complete and sign 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
https://www.coveredca.com/forsmallbusiness/applications-and-forms/

You must 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 for Small Business/CCSB P.O. Box 7010 Newport Beach, CA 92658

It is required that CCSB receive your health coverage changes no later than the 20th 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.
Employees wishing to change carriers must do so on or before the 20th of the month prior to the renewal date. For faster processing, utilize the MyCCSB portal.

Plan changes submitted through the 15th day of the renewal month will be effective retroactively to the 1st of that month. CCSB will process plan changes submitted after the 15th day of the renewal month effective the 1st of the following month.

Note: Plan changes made during the first month of coverage following the renewal period must be with the same carrier. Changes to employee coverage cannot be made after the first month of coverage following renewal, unless they experience a qualifying life event (QLE), qualify for a Special Enrollment Period (SEP), or are within the group's Open Enrollment Period (OEP).

New Hire Enrollment

Employees added to the employer group policy are guaranteed coverage until the end of the 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. Plan changes made during the first 30 days of coverage must be with the *same carrier.*

Note: Changes to employee coverage cannot be made after the first month of coverage following renewal, unless they experience a qualifying life event (QLE), qualify for a Special Enrollment Period (SEP) or are within the groups Open Enrollment Period (OEP).

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 employment. 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:

- Employees Coverage Effective date is the first of the month following 60 days from the date of hire;
- Employees Coverage Effective date is the first of the month following the date of hire
- Employees Coverage Effective date is the first of the month following 90 days from the date of hire;

When your new employee is eligible to enroll in your CCSB health plan, they should complete and submit an Employee Application prior to the effective date, but no later than 30 days after they become eligible. The Employee Application 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 for 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. 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. 10) Requests will be processed for the requested effective date unless inconsistencies are not resolved timely.

Qualifying Life Events – Special Open Enrollment Window

Employees and their dependents can enroll outside of open enrollment if they experience a Qualifying Life Event (QLE). If the employee has not experienced a qualifying life event they must wait for the next annual open-enrollment period to enroll or to make changes to their current coverage.

LIFE EVENT	TIME FRAME FOR APPLICATION	WHO CAN ENROLL?
Termination of Employment (Any Individual who is affected by the termination)	30 days from the last day of coverage	Employee plus dependents
Divorce, Legal Separation, or Loss of Dependent Status	30 days from the last day of coverage	Employee plus dependents
Reduction in Hours that led to ineligibility for benefits (Any Individual who is affected by the reduction in hours)	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
Qualified Health Plan Decertification	30 days from the last day of coverage	Employee plus dependents
Loss of Pregnancy-related Coverage	30 days from the last day of coverage	Employee plus dependents
Loss of Medi-Cal or CHIP Coverage	60 days from the last day of coverage	If employee loses, employee plus dependents. If dependent loses, dependent only.
Gains a Dependent	30 days from the event (marriage, domestic partnership decree, birth, adoption, foster care placement, QMSCO)	Employee plus dependents
COBRA/Cal-COBRA Exhaustion (does not include termination for non-payment)	30 days from the last day of coverage	If employee exhausts, employee plus dependents. If dependent exhausts, dependent only.
Erroneous Enrollment in a Qualified Health Plan (includes erroneous non-enrollment)	30 days from the date enrolled in the wrong plan	Employee plus dependents
Qualified Health Plan Misconduct	30 days from the date of the event	Employee plus 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 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 dependents
Released from Incarceration	30 days from the date of release	Employee plus dependents

Returning from Active Duty	30 days from the date of return	Employee plus 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 determined 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
Loss of Minimum Essential Coverage	30 days from the last day of coverage	If employee loses, employee plus dependents. If dependent loses, dependent only.
Domestic Abuse or Spousal Abandonment	30 days from the last day of coverage	Employee plus dependents
Loss of Medically Needed Coverage	30 days from the last day of coverage	If employee loses, employee plus dependents. If dependent loses, dependent only.
Acquires Citizenship, National Status of Lawful Presence	30 days from date acquired	Employee plus dependents
Newly ineligible for APTC or Cost Sharing reductions in Individual Marketplace	30 days from ineligible date	Employee plus dependents
Applied for Coverage during OEP and was determined to potentially be eligible for Medi-Cal or CHIP and was later determined ineligible	30 days from ineligible date	Employee plus dependents
QHP Error made to Plan Benefits, Service Area, or Premium influenced	30 days from updated Plan Benefits	Employee plus dependents
Contracted Provider no Longer Participates with QHP	30 days from Provider Notice	Employee plus dependents
Provides Proof of not enrolling due to misinformation of MEC	30 days from submission	Employee plus dependents
Becomes Eligible under Medi-Cal	60 days from the last day of coverage	If employee loses, employee plus dependents. If dependent loses, dependent only.

Qualifying Life events are subject to change based on the California Code of Regulations, for a complete list of qualifying life events please use **title 10 of the California code of Regulations, Section 6524.*

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 of discontinuation of health coverage from CCSB 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 Employee Change Request Form. Termination requests must be received prior to the last day of coverage. If an employee would like to terminate their own coverage and/or the coverage of a dependent, the employee must complete the Employee Change 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 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 Qualifying Health Plan (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 for Small Business/CCSB
P.O. Box 7010
Newport Beach, CA 92658

Change Forms sent to CCSB are typically processed within 3 business days. CCSB will mail the terminated employee or dependent a notice of termination. The employee or dependent may be eligible for COBRA or Cal-COBRA continuation coverage.

Continuing coverage 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. Continuing coverage, however, is only available when health coverage is lost due to a COBRA or Cal-COBRA qualifying event.

COBRA and Cal-COBRA Health Plan Administration

Qualified Beneficiaries

A qualified beneficiary is an individual who was covered by a group health plan on **the day of a qualifying event that caused him or her to lose coverage**. Only certain individuals become qualified beneficiaries due to a qualifying event. 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.

Continuing Coverage Health Plan Administration

The Consolidated Omnibus Budget Reconciliation Act (COBRA) and Cal-COBRA offer 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 continuing coverage. The type of continuing coverage that applies to your company is determined by the number of employees within your company.

Federal COBRA provides continuation of coverage for individuals under employer group health plans that have 20 or more FTE 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*.

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

COVERAGE 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

Continuing Coverage Qualifying Events

Continuing coverage qualifying events occur when an individual, whether an employee, spouse or dependent, to lose health coverage. 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	QUALIFYING BENEFICIARIES	FEDERAL COBRA LENGTH OF COVERAGE	CAL-COBRA LENGTH OF COVERAGE
Voluntary or involuntary termination of employment (for reasons other than gross misconduct)	Employee Spouse Dependents	18 months*	36 months
Employee becomes Entitled to Medicare	Spouse Dependents	36 months	36 months**
Divorce or legal separation	Spouse Dependents	36 months	36 months
Death of employee	Spouse Dependents	36 months	36 months
Loss of "dependent child" status	Dependent Only	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 Continuing Coverage

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

- Waives coverage
- Fails to timely elect continuing
- Voluntarily 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.

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 falls under **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 for Small Business/CCSB
P.O. Box 740167
Los Angeles, CA 90074-0167

Email: CCSBcobra@covered.ca.gov

Fax: 949-809-3264

You are responsible for submitting the Federal COBRA premiums within CCSB guidelines and Federal COBRA laws.

Termination

Continuing coverage begins on the date that a loss of coverage occurred and will end at the end of the maximum continuing coverage period. Continuing coverage may end earlier that the maximum period if premiums are not paid on time, if you choose not to maintain your group health plan, or if your former employee obtains other coverage after enrolling in continuing coverage.

Employee Termination Notices

CCSB will send termination of coverage notices to Cal-COBRA participants.

If your employer group qualifies for **Federal COBRA**, you are responsible for notifying the COBRA beneficiary directly when their COBRA health coverage has terminated.

The termination notice to the beneficiary 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 Notifications

Your former employee or eligible dependents must elect COBRA coverage within 60 days of their qualifying event. Failure to provide notification will result in their loss of health coverage continuation rights.

Federal COBRA and Cal-COBRA Coverage Payment

Federal COBRA

The Federal COBRA qualified beneficiary's premium includes 100% of the total premium plus a 2% administration fee (Not to exceed 102% of the premium cost). Premiums for Federal COBRA participants will be invoiced on your employer groups monthly invoice.

COBRA qualified beneficiaries determined to be disabled may not be charged more that 150% of the cost of coverage during the 11-month extension.

Former Employees or eligible dependents must notify **you** of their Federal COBRA coverage elections.

Cal-COBRA

If a Cal-COBRA qualified beneficiary elects to continue health benefits within 60 days of being notified of their Cal-COBRA eligibility, the initial premium payment must be made within 45 days of the Cal-COBRA election date. All Cal-COBRA premium payments are due prior to the first day of the month of coverage. Cal-COBRA beneficiaries who have not paid their premiums by the due date have a 30-day Grace Period by which to remit payment. The payment must be received by the end of the Grace Period or coverage will be terminated with no reinstatement option.

The beneficiary is responsible for the total cost which will be 100% of the total premium plus a 10% administration fee (Not to exceed 110% of the premium cost). Premium for Cal-COBRA coverage will be invoiced by CCSB directly to the enrolled CAL-COBRA participant.

Former Employees or eligible dependents must notify **CCSB** of their CAL-COBRA elections.

Cal-COBRA qualified beneficiaries determined to be disabled may not be charged more that 150% of the group rate after the first 18 months of continuation coverage.

Small Business Tax Credits

The Patient Protection and Affordable Care Act (ACA) offers federal tax credits that make providing employee health insurance more affordable. For two consecutive years, 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, offer coverage to all your employees, and pay an average annual salary of less than $56,000 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 $27,000 per year you will be eligible for the maximum tax credit amount. 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 percent.

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 for 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

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

Dental Insurance Companies

California Dental Network
http://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*" (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. *

California Department of Insurance (CDI)

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

This state agency handles complaints against some 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.*

***Note:** To locate which state agency regulates your plans, please look at your Summary of Benefits and Coverage (SBC) and Evidence of Coverage (EOC).

For your convenience, these documents can be found at:
Plans CoveredCA.com/ForSmallBusiness/Plans

Confidential Information

By law, all personal information must be kept private. Recipients of this informationshould not share personal information with those not intended to receive it.

You Have the Right to File a Complaint

You may file a complaint with Covered California for Small Business by calling **1 (877)453-9198** or visiting the "Get Help" link at https://www.coveredca.com/forsmallbusiness/other-ways-to-contact-covered-ca/ .
If your request is urgent Covered California for Small Business must give you a decisionwithin 3 days. Your request is considered urgent if there is a serious threat to your health that must be resolved quickly.

If your request is not urgent, Covered California for Small Business must give you adecision within 30 days from when we receive your request.

Right to Request Review of Rescission, Cancellation, or Nonrenewal of Your Enrollment.
If you believe that your health care coverage has been, or will be, improperly cancelled, rescinded, or not renewed, you have the right to file a grievance with the plan and or from the department that regulates your health plan. **Your health plan is regulated by either The California Department of Managed Health Care (DMHC) or the Department of Insurance (CDI).** If you do not know which Department regulates your plan, please contact Covered California for Small Business at **1 (877) 453-9198**.

You can file a complaint with the department regulating your health plan if:

- You are not satisfied with Covered California for Small Business decision aboutyour complaint.
- You have not received the decision within 30 days or within 3 days if the requestis urgent.
- The department regulating your health plan may allow you to submit a complaintdirectly to them, even if you have not filed a complaint with your health plan.

YOU MAY SUBMIT A GRIEVANCE DIRECTLY TO THE DEPARTMENT OF MANAGED HEALTH CARE.

- You may submit a grievance to the Department of Managed Health Care without first submitting it to the plan or after you have received the plan's decision on your grievance.
- You may submit a grievance to the Department of Managed Health Care online at:
- www.Healthhelp.ca.gov

You may submit a grievance to the Department of Managed Health Care by mailing your written grievance to:

Help Center, DMHC 980 Ninth St., Suite 500
Sacramento, CA 95814-2725

You may contact the Department of Managed Health Care for more information on filing a grievance at:

Phone: **1 (888) 466-2219**

TDD: **1 (877) 688-9891**

FAX: **1 (916) 255-5241**

NOTICE OF RIGHT TO REQUEST REVIEW BY THE CALIFORNIA INSURANCE COMMISSIONER

You may request a review by the California Insurance Commissioner if you believe your health insurance policy or coverage has been or will be wrongfully canceled or not renewed. To do so, you must, as soon as possible, submit your request for review in writing to:

California Department of Insurance,
Consumer Communications Bureau
300 S. Spring Street, South Tower
Los Angeles, California, 90013

or through the website: https://www.insurance.ca.gov/01-consumers/101-help/index.cfm

You may contact the California Insurance Commissioner's Consumer Communications Bureau at 1-800-927-HELP (4357) or TDD 1-800-482-4833 for information about how to request a review in writing. Please provide the Department with your health insurance policy number, copies of any letters you have received from us or a copy of your health insurance card.

You have 30 days from the date we sent this notice to you to request a review by the commissioner in order to ensure that we are required to provide you health insurance coverage while your request for review is being evaluated. To ensure that your coverage is continued without interruption, however, you must request a review by the commissioner before your coverage ends. Even if more than 30 days have passed since we sent this notice, we must continue your coverage while your request is being evaluated, as long as you request the review by the commissioner at a time when your coverage is still in effect.

Regardless of whether or not we are required to provide you health insurance coverage while your request for review is being evaluated, the commissioner will order us to reinstate your coverage, retroactive to the time of cancellation, rescission or nonrenewal, if the commissioner determines that your request for review is a proper complaint and, ultimately, that the cancellation, rescission, or nonrenewal was unlawful.

WARNING: You must continue to pay your insurance premiums on time in order to maintain coverage, and if your coverage is reinstated retroactively you will be responsible for paying insurance premiums corresponding to any gap in coverage between the time your coverage was terminated and the time it was continued or reinstated.

Continuation of Coverage

If you receive notice that your coverage is being cancelled for any reason other than failure to pay premiums **and** you still have coverage when you submit your complaint,

Covered California for Small Business must continue your coverage while they review your complaint, including any review by the DMHC Director orInsurance Commissioner. If your coverage continues, **you must still pay your usual premiums.**

If your coverage has already ended when you submit your complaint, CoveredCalifornia for Small Business does not have to continue your coverage.

If you submit a complaint to the DMHC or CDI and the Director or InsuranceCommissioner decides in your favor, Covered California for Small Business must start your coverage back to cancellation date.

Non-Discrimination Policy

Covered California for Small Business complies with applicable federal civil rights lawsand does not discriminate on the basis of race, color, national origin, age, disability or sex. Covered California does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Covered California for Small Business provides free aids and services to people withdisabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats and other formats).

Covered California for Small Business also provides free language services to peoplewhose primary language is not English, such as qualified interpreters and informationwritten in other languages.

If you need these services, contact the Civil Rights Coordinator at **1 (916) 228-8764** orby email at: CivilRights@Covered.ca.gov

If you believe that Covered California for Small Business has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age,disability or sex, you can file a grievance with the Civil Rights Coordinator.

You can file a grievance in person in any of the following ways:

Mail: Civil Rights Coordinator
P.O. Box 989725
West Sacramento, CA 95798-9725Phone: **1 (916) 228-8764**

Fax: **1 (916) 228-8909**

Email: CivilRights@covered.ca.gov

You can also file a civil rights complaint with the Office for Civil Rights at the U.S.Department of Health and Human Services.

Mail: U.S. Department of Health and Human Services
200 Independence Ave. SW, Room 509F, HHH Building
Washington, DC 20201

Phone: 1 (800) 868-1019

TTY: 1 (800) 537-7697

Online: Office for Civil Rights Complaint Portal at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available on the U.S. Department of Health and Human Services Office for Civil Rights website.

Language Line Assistance

IMPORTANT: Can you read this letter? You can call **1-(855)-777-6782** and ask for thisletter translated to your language or in another format such as large print. For TTY call**1-(888)-889-4500** where you can also request this letter in alternate format.

Español (Spanish)
IMPORTANTE: ¿Puede leer esta carta? Usted puede llamar al **1-(855)-777-6782** y pedir esta carta traducida en su idioma o en otro formato, como en letras grandes. ParaTTY, llame al **1-(888)-889-4500**, donde también puede pedir esta carta en algún formato diferente.

中文/繁體字(Chinese)
重要事项：您能否阅读此信件？您可以致电 **1-(855)-777-6782，要求将此信件翻**译为您的母语或者索要其他格式（如，大字版本）的信件。如需 TTY **服**务或者索要其他格式的信件，请致电 **1-(888)-889-4500**。

Tiếng Việt (Vietnamese)
QUAN TRỌNG: Quý vị có thể đọc được bức thư này không? Quý vị có thể gọi điện đếnsố **1-(855)-777-6782** và yêu cầu được dịch bức thư này sang ngôn ngữ của quý vị hoặcchuyển sang định dạng khác như bản in khổ lớn. Người dùng TTY, hãy gọi số **1-(888)- 889-4500** quý vị cũng có thể yêu cầu định dạng thay thế khác cho bức thư này.

한국어(Korean)
중요: 이 편지를 읽을 수 있나요? **1-(855)-777-6782** 에 연락하셔서 번역되어 있거나 인쇄물 등 다른 포맷으로 되어 있는 편지를 요청해보세요. TTY **1-(888)-889-4500**에서도이 편지의 다른 포맷을 요청할 수도 있습니다.

Tagalog
MAHALAGA: Makakabasa ka ba sa sulat na ito? Maaari kang tumawag sa **1-(855)-777-6782** at humiling na isalin ang sulat na ito sa iyong wika o sa iba pang format katulad ng malalaking titik. Para sa TTY, tumawag sa **1-(888)-889-4500** kung saan maaari kang humiling ng alternatibong format ng sulat na ito.

العربية(Arabic)

هام: هل يمكنك قراءة هذا الخطاب؟ يمكنك الاتصال بـ
1-(855)-777-6782 وطلب هذا الخطاب مترجماً إلى لغتك أو بصيغة أخرى، بخط كبير مثلاً. للصم والبكم، اتصل بـ
1 (888) 889-4500. حيث يمكنك أيضاً أن تطلب هذا الخطاب بصيغة مختلفة

հայերեն (Armenian)
ԿԱՐԵՎՈՐ Է: Դուք կարո՞ղ եք կարդալ այս նամակը: Դուք կարող եք զանգահարել **1-(855)-777-6782** և խնդրել, որ այս նամակը թարգմանվի Ձեր լեզվով կամ Ձեզ տրվի մեկ այլ ձևաչափով, օրինակ՝ խոշորատառ: TTY-ի համար զանգահարեք **1-(888)-889-4500,** որտեղ կարող եք նաև այլընտրանքային ձևաչափով խնդրել այս նամակը:

ភាសាខ្មែរ (Khmer)

សំខាន់ៈ តើអ្នកអាចអានលិខិតនេះបានដែរឬទេ? អ្នកអាចទូរស័ព្ទមកលេខ **1-(855)-777-6782** និងស្នើសុំឱ្យគេបកប្រែលិខិតនេះជាភាសារបស់អ្នក ឬជទ្រមង់

មួយផ្សេងទៀតដូចជអក្សរកាត់ៗ។ ស្រមាប់ TTY ទូរស័ព្ទមកលេខ **1-(888)-889-4500** ើដលអ្នកអាចសុំលិខិតនេះជទ្រមង់ផ្សេងទៀតបានដែរ។

Русский (Russian)

ВАЖНАЯ ИНФОРМАЦИЯ: Вы можете прочитать это письмо? Вы можете позвонить по телефону **1-(855)-777-6782** и запросить получение этого письма, переведенного на Ваш родной язык, или распечатанного крупным шрифтом. Лицасо сниженным слухом могут позвонить по телефону **1-(888)-889-4500,** чтобы запросить это письмо в ином формате.

فارسی(Farsi)

مهم: آیا می توانید این نامه را بخوانید؟ می توانید با شماره **1 (855) 6782-777** تماس بگیرید و تقاضا کنید که این نامه به زبان شما ترجمه شود یا به فرمت دیگری مانند حروف درشت به شما ارسال شود. برای TTY با شماره **1 (888) 889-4500** تماس بگیرید و از طریق همان شماره همچنین می توانید درخواست کنید که این نامه به فرمت دیگری به شما ارسال شود.

Hmoob (Hmong)

TSEEM CEEB: Koj nyeem puas tau tsab ntawv no? Koj hu tau rau **1-(855)-777-6782** nug daim ntawv txais ua yog koj cov lus los yog lwm hom xws lis tus ntawv loj. Hu tauTTY ntawm **1-(888)-889-4500** ua koj thov hloov tau lwm hom.

िहंदी (Hindi)

महत्वपूर्ण: क्या आप इस पत्र को पढ़ सकते हैं? आप **1-(855)-777-6782** पर कॉल कर इस पत्र को अपनी भाषा में अनुवादित करवाने या किसी अन्य फॉर्मेट में जैसे कि बड़े प्रिंट में बदलवाने के लिए कह सकते हैं। टीटीवाई (TTY) के लिए **1-(888)-889-4500** पर कॉल करें जहाँ आप इस पत्र का अनुरोध किसी अन्य फॉर्मेट में भी कर सकते हैं।

ਪੰਜਾਬੀ (Punjabi)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਤੁਸੀਂ **1-(855)-777-6782** 'ਤੇ ਕਾਲ ਕਰਕੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਨ ਲਈ ਜਾਂ ਕਿਸੇ ਹੋਰ ਫਾਰਮੈਟ ਜਿਵੇਂ ਕਿ ਵੱਡੇ ਿੰਟ ਲਈ ਪੁੱਛ ਸਕਦੇ ਹੋ। ਟੀਟੀਵਾਈ (TTY) ਲਈ **1-(888)-889-4500** 'ਤੇ ਕਾਲ ਕਰੋ ਜਿੱਥੇ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਦੇ ਕਿਸੇ ਹੋਰ ਫਾਰਮੈਟ ਲਈ ਬੇਨਤੀ ਵੀ ਕਰ ਸਕਦੇ ਹੋ।

ไทย (Thai)

สงิ สาคัญ : คุณอ่านจดหมายนไี้ ดไหม? ใหคุณโทรไปทหี่ **1-(855)-777-6782** เพอื่ ขอรบการแปลจดหมายนเี้ ป็นภาษาของคณหรุ อจะขอใหทำในรูปแบบอนื่ ๆ เชนพม

พใ่ นขนาดทใี่ หญ่ สำหรบการส่งขอความใหโทร **1-(888)-889-4500** เพอื่ ขอใหทำจดหมายนเี้ ป็

นรูปแบบอนื่ ๆ

日本語(Japanese)

重要：この文書を読むことができますか？希望の言語に翻訳された文書、または大きな文字など別の形式の文書をご希望の場合、**1-(855)-777-6782**までお電話ください。TTYの場合は、 **1-(888)-889-4500** にお電話いただければ、その他の形式の文書をリクエストすることもできます。