COVERED CALIFORNIA FOR SMALL BUSINESS EMPLOYER GUIDE

COVERED CALIFORNIA
SMALL BUSINESS

WELCOME TO COVERED CALIFORNIA FOR SMALL BUSINESS

Covered California for Small Business (CCSB) is a part of Covered California where employers with 100 or fewer full-time equivalent employees (FTEs) can access brand name health and dental insurance plans to provide quality, affordable health covered services 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 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 covered services 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 the employer dashboard
- Access to employer invoices
- Review employees' eligibility status and health and dental insurance plan assignment
- View eligibility transactions
- Process additions and terminations for employee(s)
- 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 and last Name, and Primary Phone Number and 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.

For assistance in navigating the My CCSB Portal, reference CCSB Enrollment Online Portal Employer Guide and My CCSB Renewal Functionality User Guide available on myccsb.com.

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Responsibility and Privacy

Your Health Plan Responsibilities

While CCSB handles most of the administrative work to make offering health and dental insurance plans 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 and dental insurance plans 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 Tiers and Premium Contribution
4. Following Privacy Guidelines
5. Deciding on Employee and Dependent Eligibility
6. Setting a New Hire Election Period
7. Paying Your Monthly Premium 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 and Dental Insurance Plan Documents & Resources

In these pages, you will find information on your responsibilities with details that can help you manage a health insurance program for your employees. These include understanding privacy rules, knowing which of your employees are eligible for coverage, what to do if you need to change 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 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 provide confidential information. Protecting this information is of utmost importance to CCSB. Any information collected from an 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 company unless strictly necessary for determining eligibility and enrollment. As an employer who sponsors a health plan, you need to be cautious when disclosing sensitive and personal information. Employers must always adhere to applicable privacy laws and rules to ensure the personal and health information of their employees remains confidential and protected. To review Covered California's privacy practices, please visit www.coveredca.com/privacy.

Employer Eligibility Guidelines

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 the employer offers Coverage to each eligible employee serving that employee's primary worksite.
- At least one employee must receive a W-2; the employee cannot be an owner or the spouse of an owner.
- Employers must offer CCSB coverage to all eligible employees.
- Employers must comply with the employee participation requirement.
- The majority of employees are employed within California.
- Employers 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).

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). Information on how to perform the FTE calculation can be found using the Employer Shared Responsibility Provision (ESRP) Estimator.

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 FTE count has exceeded 100 employees.

Employer Effective Dates

Effective dates for group coverage are the 1st of each month. For health insurance plans to start on the 1st of the following month, group applications must be submitted five calendar days prior to the effective date. Covered California for Small Business (CCSB) will accept new-business submissions no later than the 7th calendar day of the requested effective month, provided a New Business Late Submission Acknowledgement Form is signed and submitted with the enrollment application. If the group does not submit the late submission form, the effective date will be the first of the month following the requested effective date.

Knowing Your Status

Applicable Large Employers

The Affordable Care Act (ACA) is a federal law that changed the healthcare landscape in the United States in 2010. The ACA requires employers of a certain size (50 or more FTEs) to offer health 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 provides “minimum value” to your full-time employees. The law also requires ALEs to offer coverage to full-time employees for their dependent children below the age of 26. ALEs that do not offer health coverage to their full-time employees and their dependents could face a penalty from the Internal Revenue Service (IRS) referred to as the Employer Shared Responsibility Payment. This penalty is triggered if the ALE does not offer coverage to at least 95 percent of its full-time employees and at least one full-time employee receives a federal subsidy to help pay for marketplace coverage or if the ALE offers coverage to at least 95 percent of its full-time employees and a full-time employee receives financial help from a marketplace because the coverage is not affordable or does not provide minimum value or the employee is not one of the full-time employees offered coverage.

If you have less than 50 FTEs, you are considered a small business by the ACA and are not legally required to offer health coverage or pay a penalty. Regardless of 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, attract employees, and help with a company’s retention.

Offering coverage through CCSB can help you avoid the Employer Shared Responsibility Payment and provide your employees with access to quality, affordable ACA-compliant health insurance 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 groups, 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 eligible for coverage through the CCSB program but are also required to offer health coverage as an ALE.

Contribution and Participation Requirement

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 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 when you enroll in CCSB and 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 selected on your behalf. The auto-selected reference plan, which determines your contribution cost, will be the lowest cost plan in the same metal tier as the previous plan. The contribution percentage amount for your employees will remain the same as previously elected.

Employee Participation 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 Enrollment Period

You can enroll in CCSB at any time throughout the year if you have at least 70% of your employees enrolled in a health or dental insurance plan and contribute at least 50% of the cost towards your employees' premiums. If you fail to meet the minimum employee participation or contribution requirements, CCSB offers an Annual Enrollment Period every year from November 15 to December 15 when employers that meet all other eligibility guidelines are allowed to enroll with health or dental insurance plans 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 the minimum participation or premium contribution requirements to enroll in a health or dental insurance plan. This annual enrollment period allows you to enroll even if only a few employees accept coverage, or 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 insurance 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 Insurance Plans

Employers and their employees have expanded opportunities for improved dental coverage insurance through CCSB family and pediatric dental plans. Dental insurance plans are an elective benefit that you can choose to offer as part of your health insurance program. If you choose to offer dental insurance to your employees, then you must select a Dental Reference Plan and choose how much you want to contribute to your employee's dental premiums.

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 employee's cost.
- Family dental plans offer covered services for both Employee(s) and their family. Employee(s) can choose to enroll in a family plan without enrolling the entire family.

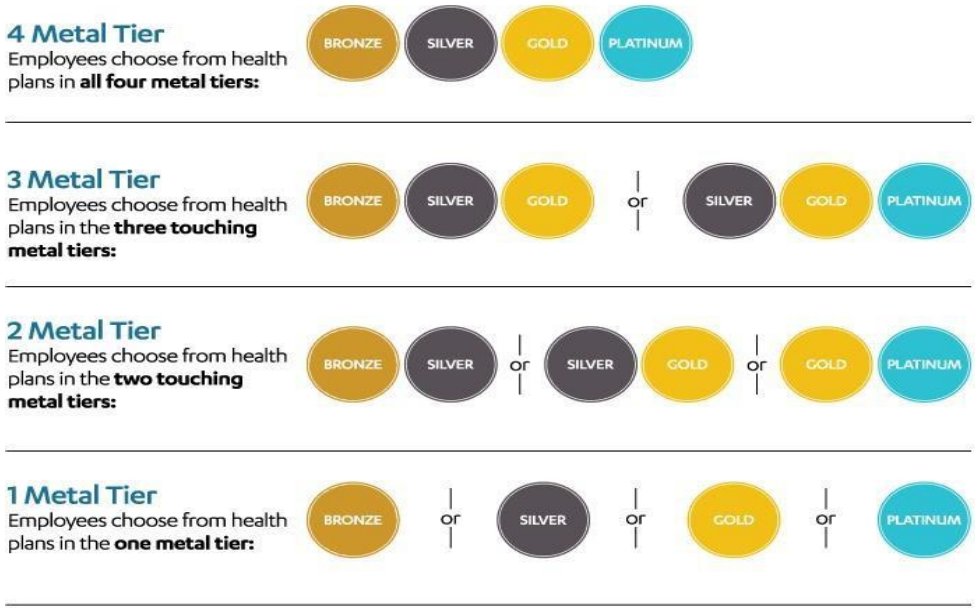
Pediatric Dental:

- The pediatric dental plan is for children up to 19 years of age.

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

Metal Tier Health Insurance 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 insurance plan options, allowing them to find one that fits their needs and budget.



Offering CCSB Health Insurance Plans Alongside Other Coverage

If Employers offer non-CCSB health coverage alongside our coverage, that coverage should only include fully insured, aged-rated, ACA-compliant small group or small group grandfathered health insurance plans. Employers should not offer health plan options such as non-ACA-compliant plans, composite rate plans, level-funded or self-funded plans, or association health plans (AHPs) alongside CCSB coverage.

Eligibility & Verification

Employer Eligibility & Verification

CCSB will verify your eligibility as a business owner before allowing you to offer health insurance plans 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 application, CCSB will provide you with written notice of the discrepancy. From the date of the 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 calculation, part-time employees must be permanent employees who work between 20 and 29 hours per week and are 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 CCSB health insurance plans 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 with 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 with written notice. You have 30 days from the date of the notice to resolve the inconsistency. If no response is received within 30 days, 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 who waives their coverage is not eligible to enroll in your health or dental insurance plan until your next open enrollment period or during a special enrollment period triggered by a qualifying life event.

Dependent Eligibility & Verification

Should you elect to offer dependent coverage, enrollees and their dependents must enroll in the same health or dental plan. Dependent children who are eligible for health coverage through CCSB must be under the age of 26. Dependent children 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 pediatric dental and pediatric vision coverage. Please refer to your Evidence of Coverage (EOC) for more information.

Did You Know?

You can elect to offer employee-only coverage. If you're an Applicable Large Employer and choose to offer employee-only coverage, you may be subject to the Employer Shared Responsibility Provisions.

If you 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 Provisions go to www.irs.gov/affordable-care-act

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 30 days, 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. Appeals must occur within 90 days from the date of the denial notice. Once an appeal is submitted, CCSB will provide a written response to the appeal. 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 due to the appeal process, the eligibility decision is backdated and effective starting the date of the incorrect determination.

An Appeal form can be found on CCSB's website at Small Business Appeal Form. For questions regarding the appeals process, contact the CCSB Service Center at (855) 777-6782. Additional information can also be found at: www.cdss.ca.gov/inforesources/state-hearings

Appeals can be submitted in one of the following ways:

1. **Submitted Electronically:**
    - **Online:** cdss.ca.gov/hearing-requests
    - **Email:** ACRABOps@dss.ca.gov
    - **Fax:** (833) 281-0905

2. **In Writing:**

    CA Department of Social Services
    Attn: ACA Bureau
    P.O. Box 944243, Mail Station 9-17-37
    Sacramento, CA 94244-2430

Submit your appeal in person at your local county welfare department (call Covered California and we can refer you to your local CWD).

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

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, business name or primary contact, address, or 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 insurance plan options for both you and your employees (see Your Premiums & Payments on page 16). Address changes will be updated effective the first of the following month after receipt. However, if the address change impacts the premium 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 Form. The form 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 must be reported include an employee's:

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

All changes should be submitted using an Enrollment and Employee Change Request for Employees Form within 30 days of the event. Enrollment and Employee Change Request for Employees Forms can be found at CoveredCA.com/ForSmallBusiness/Resources CoveredCA.com/forsmallbusiness/applications-and-forms in both English & Spanish.

In the case of birth, adoption, placement for adoption, placement in foster care, and assumption of a parent-child relationship, coverage is effective for that enrollee on the date of birth, adoption, placement for adoption, placement in foster care, or assumption of a parent-child relationship, or on the first day of the following month if requested by the enrollee. The premiums will be pro-rated based on the number of days they had coverage. The pro-rated premium will be determined by dividing the total monthly premium by the number of days in the month and then multiplying the daily amount by the number of days

covered in that month.

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 their dependents to reflect on your invoice. With myCCSB.com, you can quickly update and view your account online. Expanded functionality includes:

- Complete your renewal faster on MyCCSB.com.
- Submit and confirm employee(s) and 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
- Number of FTEs
- Dependent coverage
- Dental insurance plans
- Infertility coverage

Making Changes to Employee Applications

nAfter enrollment, eligible employees can change their selected health or dental insurance plan during the first 30 days of the new plan year if the newly selected health or dental

insurance plan is offered by the same health or dental insurance company. Health and dental insurance 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 1st of the following month. Health and dental insurance plan changes received between the 16th and last day of the month will be effective the 1st of the following month.

Suppose an employee's health insurance plan is discontinued at renewal. In that case, the employee and their dependents will be enrolled in the lowest-cost health insurance plan with the same health insurance company, and the same metal tier. If the same health insurance plan is unavailable with CCSB, the employee and their dependents will be enrolled in the lowest-cost health insurance plan with a different health insurance company, within the same metal tier.

Please refer to your Renewal Packet for details, in the event, that the employee's dental insurance plan or the dental insurance company is discontinued at renewal.
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 periods, see **Qualifying Life Events – Special Enrollment**.

Your Premiums & Payment for Health Coverage

Your Premiums

Health insurance plan 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 insurance plan. Your address will fall in one of the 19 rating areas in California that determine your health insurance premiums.

Maximum Premiums for Dependents

When calculating monthly premiums or generating quotes, there's a cap on the premiums for dependents under the age of 21, with only the premiums for the three oldest dependents being charged in a family, regardless of it being a single or dual-parent household. The premiums are determined based on the three oldest under the age of 21. For instance, if employee John Smith enrolls with his six children, and four are under 21 and two are older, the premium will include charges for John, the three oldest dependents under 21, and the two dependents who are 21 or older. The youngest dependent under 21 would not incur a charge under this policy.

Making Premium Payments

Initial Payment

Although employees can choose from multiple health and dental insurance companies, CCSB will send you a single invoice accounting for all health and dental insurance plans. CCSB must receive the initial payment for the total amount billed by the due date on 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 application.

Ongoing Payments

The billing cycle starts on the 1st of each month. CCSB will send you an invoice on or about the 15th of each month for your monthly premium for the upcoming month of coverage. Payment must be delivered to CCSB by the last day of the invoicing month. On-going monthly 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 due. 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 by the due date indicated on the invoice, CCSB will mail a Notice of Start of Grace Period on the day after your monthly 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 monthly payment to maintain covered services and your right to request a review of the cancellation by an applicable regulator.

If coverage is terminated due to non-payment, you will be notified of the reason and sent a Notice of Termination. 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, beginning from the time of the original effective date or most recent renewal date, whichever is most recent. If you request reinstatement 31 or more days following the effective date of the termination, you must reapply for a new group health or dental insurance plan.

Grace Period

An employer group will receive a grace period of 30 days to remit payment for all past-due balances. If the total balance due is not received before the expiration of the 30-day grace period, coverage will be terminated. A Notice of Termination will be sent after the termination. Pursuant to California's State Accounting Manual's collection policies, CCSB will send three collection letters for outstanding monthly payments at 30-day intervals. If a response is 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.

Monthly 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 returned monthly payments could result in delinquency of payment. CCSB will apply a $25 return fee for any returned monthly payments.

If two returned monthly payments are made in a six-month period, you must submit monthly 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 return 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 your employees. CCSB will send you a written notice of your plan renewal and annual election period 60 days before the end of your plan year. During this time, you can explore health and dental insurance plan options and make changes to your reference plan or contributions. 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 coverage changes, you can start an open enrollment period for your employees to make their health and dental insurance 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 for 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 insurance plan, making plan changes, and renewal sheets for each employee with information about their existing coverage and monthly premium changes.

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. 25)

qualified beneficiaries of:

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

You are responsible for notifying your eligible employees of the health and dental insurance plans available to them through CCSB. It is important that you provide both the renewal sheets and the Employee Change 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 (SBCs) and health and dental insurance plan 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

Applications and Forms
https://www.coveredca.com/forsmallbusiness/applications-and-forms/

You must submit Employer Change Forms and Enrollment and Change Request for Employees 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

Note: Health and dental insurance plan changes made during the first month of coverage following the renewal period must be with the same health or dental insurance company. Changes to employee coverage cannot be made after the first month of coverage following renewal unless they experience a qualifying life event (QLE) and qualify for a Special Enrollment Period (SEP).

New Hire Enrollment

New employees added to the employer group policy can remain enrolled through the end of the plan year. A new hire is eligible for a health or dental insurance plan on 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. A newly eligible employee has a 30-day period to enroll in a health or dental insurance plan beginning on the first day the employee becomes eligible.

Deciding on a Waiting Period

The waiting period for health insurance plans cannot exceed 90 calendar days after an employee is otherwise eligible for coverage. 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 three scenarios would be in compliance:

- Employee's coverage effective date is the first of the month following the date of hire.
- Employee's coverage effective date is the first of the month following 30 days from the date the employee meets the eligibility requirements.
- Employee's coverage effective date is the first of the month following 60 days from the date of hire or the employee meets the eligibility requirements.

When your new employee is eligible to enroll in your CCSB health or dental insurance 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 in a health or dental insurance plan 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 you or your employee of these inconsistencies and of an eligibility determination (See Employee Eligibility & Verification on pg.11) Requests will be processed for the requested effective date unless inconsistencies are not resolved timely.[1]

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

Qualifying Life Events – Special Enrollment Period

Employees and their dependents can enroll outside of open enrollment if they experience a Qualifying Life Event (QLE). Employees and their dependents have 30 days from the date of the event to enroll or change plans for most QLEs and 60 days from the date they lose or gain Medi-Cal coverage to enroll or change plans. All family members can enroll or change plan if any family member experiences a QLE. For example, if a dependent loses other health coverage, the employee and any other dependents can also enroll or change plans. If the employee or their dependent(s) 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.

Loss of Minimum Essential Coverage including:

- Loss of employer-sponsored coverage from a different employer
- Loss of Medi-Cal or CHIP coverage
- Loss of Pregnancy-related Medi-Cal coverage
- Loss of Medically Needy Medi-Cal coverage
- Loss of student health coverage
- Loss of eligibility for health coverage due to:
- Legal separation
- Divorce
- Turning 26 years old and no longer eligible under parent's plan
- Turning 19 and no longer eligible for a child-only plan
- Death in the family
- Termination of employment
- Reduction in hours that led to loss of coverage
- Current health or dental insurance plan through CCSB is no longer available
- Termination of employer contributions towards health insurance plan, including current or former employer
- COBRA/Cal-COBRA exhaustion (does not include termination for non-payment)
- Loss of coverage because of a permanent move out of an HMO service area

Gains a Dependent due to birth, adoption, foster care placement or child support order or other court order

Marriage or entered domestic partnership

Misrepresentation or Erroneous Enrollment in a Qualified Health Plan (includes erroneous non-enrollment)

Health Insurance Company Error including:

- Incorrect data displayed on premiums, benefits or copays/deductibles, or incorrect
- plans
- Health insurance company violated its contract
- Family could not enroll together in a single plan
- Material error to plan benefits, service area, cost-sharing (copay, coinsurance,
- or deductible), or premium that influenced enrollment decision

Permanent move to or within California including:

- Move to California from out of state
- Move within California and gain access to at least one new CCSB health insurance plan

Released from incarceration

Returning from active-duty military service

Federally recognized American Indian/Alaska Native (allowed to enroll or change plans once per month)

Applied for Coverage during open enrollment and was determined to be eligible for Medi-Cal or CHIP potentially and was later determined ineligible

Required by court order to provide health insurance for a child who has been determined ineligible for Medi-Cal and CHIP, even if not expecting to claim the child as a tax-dependent

Provider left the health insurance plan network and employee or dependent was receiving care for:

- Pregnancy
- Terminal Illness
- An acute condition
- A serious chronic condition
- Care of a newborn child between birth and age 36 months
- A surgery or other procedure that will occur within 180 days of the termination or start date

Provides Proof of not enrolling due to misinformation about MEC

Becomes Eligible for Medi-Cal or CHIP coverage

Other Exceptional Circumstances (determined on a case-by-case basis, consult with a CCSB representative)

**For a complete list of Qualifying Life Events please see Title 10 of the California Code of Regulations, Section 6530*

Terminating Coverage

Terminating Your Small Business Coverage

To terminate health or dental insurance for your company, you must provide written notice to CCSB before the end of the month in which coverage should end. For notifications received on or before the 15th of the month, terminations will become effective at the end of the month in which it was received. Terminations received after the 15th of the month will become effective at 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 Covered California.

Terminating Coverage for an Employee or Dependent

To terminate coverage for an employee that has left employment or is no longer eligible, please complete the Employee Change Form. Termination requests must be received before the last day of coverage. If an employee would like to terminate their own coverage or their dependent's coverage, the employee must complete the Enrollment and Change Request for Employees Form.

The coverage termination effective date for an employee and their 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 health or dental insurance company. However, the effective date of termination may be no date other than the last day of the month.

Employer Change Form and Enrollment and Change Request for Employees 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

Enrollment and Change Requests 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.

COBRA and Cal-COBRA Health Plan Administration

Qualified Beneficiaries

A qualified beneficiary is an individual who was covered by a group health or dental insurance plan on **the day of a qualifying event that caused them 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 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 or dental insurance plan for limited periods of time. COBRA and Cal-COBRA is available 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 or qualified beneficiary elects to continue the group health or dental insurance plan, the coverage generally will be the same coverage that the qualified beneficiary had immediately before the qualifying event. The continuation coverage must 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 right to add qualified beneficiary dependents
- The rights to remove dependents voluntary; and
- The right to remove dependents when they are no longer eligible for coverage.

There are two types of continuation coverage. The type of continuation 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 the employer group health or dental insurance plans that have 20 or more eligible employees. It is your company's responsibility to be informed of your responsibilities and obligations under COBRA including the required notices. Federal COBRA is administered by the employer or by a Third-Party Administrator (TPA) hired 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 insurance 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.

Note: If your Eligible Employee count changes, you may transition the COBRA coverage type during your group's annual renewal period or in January of the upcoming calendar year.

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

Continuing Coverage Qualifying Events

Continuing coverage qualifying events occur when an employee, spouse, or dependent loses 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 from employee	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 18 months of continuation coverage may become entitled to a disability extension of an additional 11 months (for a total maximum of 29 months) or an extension of an additional 18 months due to the occurrence of a second qualifying event (for a total maximum of 36 months).

** The actual period of continuation coverage may vary depending on factors such as whether the Medicare entitlement occurred prior to or after the end of the covered employee's employment or reduction in hours.

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 continuation coverage.
- 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 with 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. It is your company’s responsibility to be informed of your responsibilities and obligations under COBRA

including the required notices. For more information on Federal COBRA coverage, please visit *https://www.dol.gov/general/topic/health-plans/cobra*.

Election Notices

For **Cal-COBRA** (2 to 19 employees), you must notify CCSB of any employees or dependents who experience a qualifying event. CCSB will send eligibility notifications to your terminated employees on your behalf. Former Employees or eligible dependents must notify CCSB of their CAL-COBRA elections.

How Should I Process a Federal COBRA Election Form?

When you receive a Federal COBRA election form from the qualified beneficiary within their 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 7010
Newport Beach, CA 92658

Email: CCSBeligibility@covered.ca.gov

Fax: 949-809-3264

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

Termination

Continuation coverage begins on the date that a loss of coverage occurred and will end at the end of the maximum continuation coverage period. Continuation coverage may end earlier than the maximum period if premiums are not paid on time if you choose not to maintain your group health or dental insurance plan program, or if your former employee obtains other coverage after enrolling in continuation of coverage. Generally, CCSB will send termination of coverage notices to Cal-COBRA participants. However, if you choose to end group coverage with CCSB, you are responsible for notifying Cal-COBRA beneficiaries of their option to change their health or dental insurance plan to any other group plan that you offer for the remainder of their continuation coverage period.

Coverage Payment

Federal COBRA

Premiums for federal COBRA qualified beneficiaries will be invoiced on your employer group's monthly invoice. The employer group is responsible for the administration of federal COBRA.

Cal-COBRA

If a Cal-COBRA qualified beneficiary elects to continue health benefits within 60 days of their Cal-COBRA qualifying event or being notified of the ability to continue coverage under the group health insurance plan, the initial premium payment must be made within 45 days of the Cal-COBRA election date. All continuing 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 premium for Cal-COBRA coverage will be invoiced to the Cal-COBRA qualified beneficiary directly and will not reflect on the Employer invoice.

The qualified beneficiary is responsible for the total cost which will include 100% of the total premium plus a 10% administration fee (not to exceed 110% of the premium cost).

Cal-COBRA qualified beneficiaries determined to be disabled may not be charged more than 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 $65,000 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 $32,000 per year (adjusted annually for inflation) 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 employees 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.

Example of a Small Business Receiving Tax credits for Health Insurance

Veterinary Office With 10 Full-Time-Equivalent Employees	
Wages	$270,000 total, or an average of $27,000 per employee**
Employer Contribution for Health Insurance	$80,000 per year
Tax Credit (Year 1)	$40,000 (50%)
Tax Credit (Year 2)	$40,000 (50%)
Tax Credit (Year 3)	Not eligible for tax credit

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 www.covereda.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 Change Form and Enrollment and Change Request for Employees
  - COBRA Forms & Notices
  - Appeal & 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 get in touch with 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
www.blueshieldca.com
(855) 836-9705

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

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

Dental Insurance Companies

Delta Dental of California
www.deltadentalins.com
DPPO: (800) 471-0173
DMHO: (888) 282-8528

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 healthcare 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 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 insurance company. 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 health insurance company if coverage was denied based on lack of medical necessity or if a treatment is 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 insurance company. 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 health and dental insurance 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 information should 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 www.coveredca.com/forsmallbusiness/other-ways-to-contact-covered-ca/

If your request is urgent Covered California for Small Business must give you a decision within 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 a decision 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 canceled, rescinded, or not renewed, you have the right to file a grievance with the health insurance company and or from the department that regulates your health insurance plan.**Your health insurance company 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 and dental insurance company if:

- You are not satisfied with Covered California for Small Business's decision about your complaint.
- You have not received the decision within 30 days or within 3 days if the request is urgent.
- The department regulating your health and dental insurance plan may allow you to submit a complaint directly to them, even if you have not filed a complaint with your health and dental insurance company.

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 health and dental insurance company 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 your 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 with 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 canceled 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 or Insurance Commissioner. If your coverage continues, **you must still pay your usual monthly premiums**.

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

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

Non-Discrimination Policy

Section 1557 of the Patient Protection and Affordable Care Act (ACA)

Covered California complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, sexual orientation, sex characteristics including intersex traits, sex stereotypes, or pregnancy and related conditions. Covered California does not exclude people or treat them differently because of race, color, national origin including primary language and limited English proficiency, age, disability, sex, gender identity or sexual orientation.

Covered California provides reasonable modifications and free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, auxiliary aids and services, and written information in other formats (large print, audio, accessible electronic formats and other formats). Covered California also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact the Section 1557 Civil Rights Coordinator at 916-228-8764 or by email at CivilRights@covered.ca.gov. Or go to CoveredCA.com/accessibility.

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

You can file a grievance in the following ways:

Mail: Section 1557 Civil Rights Coordinator
P.O. Box 989725
West Sacramento, CA 95798-9725

Phone: 916-228-8764

Fax: 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: 1-800-368-1019 or 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 this letter 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 مترجما إلى لغتك أو بصيغة أخرى، بخط كبير مثـ ًلا. للصم والبكم، اتـ
صـ
لـ
بـ

حيث يمكنك أيضا أن تطلب هذا الخطاب بصيغة مختلفة**1 (888) 889-4500**.

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:

ខ្មែរ (Khmer)

សូមអានលិខិតនេះ ប្រសិនបើអ្នកមិនយល់ ឬត្រូវការព័ត៌មានបន្ថែម សូមទូរស័ព្ទទៅលេខ **1-(855)-777-6782** ដើម្បីស្នើសុំឱ្យបកប្រែលិខិតនេះជាភាសារបស់អ្នក ឬសុំឯកសារជាអក្សរពុម្ពធំ។ បើអ្នកថ្លង់ ឬពិបាកស្តាប់ សូមទូរស័ព្ទទៅលេខ TTY **1-(888)-889-4500** ដើម្បីស្នើសុំឯកសារជាទម្រង់ផ្សេង។

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.

हिंदी (Hindi)

महत्वपूर्ण: क्या आप इस पत्र को पढ़ सकते हैं? आप **1-(855)-777-6782** पर कॉल कर इस पत्र कोअपनी भाषा में अनुवादित करवाने या किसी अन्य फॉर्मेट में जैसे कि बड़े प्रिंट में बदलवानेकेलिए कहसकते हैं। टीटी वाई (TTY) केलिए **1-(888)-889-4500** पर कॉल करें जहां 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 ਕਸੇ ਹੋਰ ਫਾਰਮੈਟ ਵਿੱਚ ਜਵਾਬ ਦੇਣ ਲਈ ਪੱਤਰ ਬਾਰੇ ਪੁੱਛ ਸਕਦੇ ਹੋ। ਟੀਟੀਵਾਈ (TTY) ਲਈ
1-(888)-889-4500 'ਤੇ ਕਾਲ ਕਰੋ ਜੱਥੇ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਦੇ ਕਸੇ ਹੋਰ ਫਾਰਮੈਟ ਲਈ ਬੇਨਤੀ ਵੀ ਕਰ ਸਕਦੇ ਹੋ।

ไทย (Thai)

: คุณอ่านจดหมายนไี้ ดไหม? ใหคุณโทรไปท ี่ **1-(855)-777-6782**

เพื่อ ขอรบการแปลจดหมายนเี้ ป็ นภาษาของคณหรุ อจะขอใหท้ าในรู ปแบบอนื่ ๆ เชนพม

พโ่ นขนาดทใี่ หญ่ สำหรบการส่งขอความใหโทร **1-(888)-889-4500** เพื่อ ขอใหท้ าจดหมายนเี้ ป็

นรู ปแบบอนื่ 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。