COVERED CALIFORNIA SMALL BUSINESS	***Covered California for Small Business (CCSB) Eligibility & Enrollment Insurance Agent Guide***
TOPIC	**GUIDE**
Employer Eligibility	
Carve-Outs	Carve-Outs are not allowed. Union employees are not eligible unless their union benefits are not subject to collective bargaining through the union.
Change in Ownership Prior to Renewal of In Force Group	If an employer group is sold before the end of the plan year, the new owner may make changes to the business name, FEIN, address, etc. Any material changes (health insurance plan, Metal Tiers - coverage levels such as bronze, silver, gold, or platinum, etc.) cannot be made until the group renews unless the new owner terminates the health insurance company and submits documents to reapply as a new group.
Employee health and dental insurance plan changes within the first 30 days	Within the first 30 days of the effective date, the employee can only make changes within the same health or dental insurance company. Changing the health or dental insurance company is only permitted prior to the effective date.
COBRA Administration	For groups with 2-19 employees, CCSB invoices Cal-COBRA beneficiaries directly. Employers with 20 or more employees are responsible for administering Federal COBRA.
Composite Rating	Composite rates are not available for CCSB plans.
Reference Plan	A group must select a reference plan within its requested metal tiers (coverage levels such as bronze, silver, gold, or platinum). The reference plan is chosen to determine the amount the employer will contribute towards the employee's monthly premium, which is your monthly payment to your health insurance company.
Contribution Requirements	To participate in CCSB, employers must contribute a minimum of 50 percent of the lowest-cost employee-only monthly premium. This requirement is not enforced during the Annual Enrollment Period from November 15th – December 15th each year for a January 1st effective date.
Domestic Staff Coverage	Employers wishing to cover their domestic staff must provide a DE-9C (or 1 month of payroll if the business is less than 3 months old) and meet all applicable eligibility guidelines.
Effective Dates	Effective dates for group coverage are the 1st of each month. For coverage to start the 1st of the following month group applications need to be completed and submitted at least five calendar days before the end of the month. 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 agree to the submission acknowledgment, the effective date will be the first of the month following the requested effective date.
Eligible Employees	Eligible employees include: • Full-time permanent employees (average of 30 hours a week measured of a month). • Part-time employees (part-time employees who work 20-29 hours per week • and coverage offered to part-time employees at owner's discretion).

Employee Only Coverage	Employers can apply for employee-only coverage. Dependent coverage is optional. However, under the Affordable Care Act's(ACA) employer shared responsibility provisions, certain employers (called applicable large employers or ALEs) must either offer minimum essential health benefits that are "affordable" and that provide "minimum value" to their full-time employees (and their child dependents below the age of 26- spouse coverage is not mandated), or potentially make an employer shared responsibility payment to the IRS. Please visit the IRS website for details. https://www.irs.gov/affordable-care-act/employers/aca-information-center-for-applicable-large-employers-ales
Employee Monthly Premium Rates and Location	Generally, the Employee's monthly premium rates are based on the employer's California principal business address zip code.
Employee Monthly Premium Rates – Age	Employee monthly premium rates are based on the age of the employee/dependents at the time of enrollment.
Employer address changes and OE or SEP	1. An address change that results in a rating region change takes effect at the next renewal, not at the date of the address change. 2. A change in the physical address for an employer may or may not trigger a new enrollment period for employees as follows: • Employers may choose not to start a new health and dental insurance plan year based upon the move and will continue their policy with CCSB (no OE). Available health and dental insurance plans must still be based on their old address. Employees who move with the employer so that they no longer live or work in the service area of their previously chosen health and dental insurance company may select a plan that is available to them at their new location, due to a qualifying life event triggering a SEP.). • Employer(s) may choose to reapply for their policy with CCSB based on their new address. A new plan year would begin in this instance and rates would reflect those in place as of the date of the new plan year. Health and dental insurance plans availability and updated rates will be reflected during the reapply process. • No new enrollment period (no SEP or OE) would be triggered if the employer does not reapply for a new policy and employees did not relocate. Health and dental insurance plan availability and updated rates will be reflected during the group's next renewal.
Group Size	Employers are eligible to purchase coverage for their employees and dependents in CCSB if they have 1 to 100 full-time equivalent (FTE) employees. An eligible employee works an average of 30 hours per week or 120 hours per month based on a month of work. An employer can decide to offer coverage to part-time employees who work between 20 and 29 hours per week. Please visit the IRS website for assistance. https://www.irs.gov/affordable-care- act/employers/small-business-health-care-tax-credit-and-the-shop-marketplace

Groups That Grow Over 100	A small business that is enrolled in CCSB and grows to exceed 100 full-time equivalent employees will be allowed to renew their coverage if the employer continues to meet CCSB eligibility requirements, including contribution and participation requirements.
Minimum Group Size	The minimum group size is 1 FTE. Employers and spouses do not count as FTEs to determine group size. The only way an employer and spouse-only group could be eligible is if the required "common law employee" works as an FTE or a minimum of 30 hours per week on average. Otherwise, they would have less than 1 FTE.

New Business Materials Submission Deadline	The submission deadline is 5 business days before the requested effective date. Completed submissions received after the deadline will carry an effective date no earlier than the first of the following month unless the employer submits a signed CCSB New Business Late Submission Acknowledgement Form.
New Businesses	New businesses that are applying for CCSB must adhere to the requirements specific to their business type per Step 1 of the Employer Application. These requirements also provide the necessary documentation to verify eligibility based on the business type.
Owner/Partnership Eligibility	Owners/Officers are eligible and do not need to be on payroll to qualify for CCSB. However, employers must provide appropriate documentation for owners/officers to verify eligibility and must have at least (1) common law employee other than the Owner/Officer. *This requirement also applies to nonprofit organizations.* Please refer to Step 1 of the Employer Application for instructions.
Participation Requirements	A minimum of 70 percent of eligible employees must participate with CCSB. If the employer pays 100 percent of the employees' monthly premiums, then all eligible employees not waiving coverage must enroll through CCSB. Valid waivers are not required to enroll and are not counted when calculating participation. Employers not meeting participation requirements may still sign up during the Annual Special Enrollment Period (Nov. 15th - Dec. 15th).
Percentage of COBRA Participants Allowed	There is no maximum percentage of COBRA or Cal-COBRA participants an enrolling employer group may have.
Placing Business with CCSB and Another Health Insurance Company	Placing Business with CCSB and another health insurance company is allowed if at least 70% of eligible employees who do not have a valid waiver are enrolled with CCSB, except if the enrollment occurs during the Annual Special Enrollment (Nov 15 - Dec 15). The Annual Special Enrollment Period allows employers to enroll without meeting the CCSB participation and/or contribution requirements.
Plans for Out of State Dependents	Dependents who reside out of state are eligible for services only in their plan's service area within California or for emergency coverage outside of California. Certain PPO (A health insurance plan where you can get care from in-network or out-of-network providers without a referral (cost varies between in and out-of-network). plans include out-of-state providers in their networks outside of California.
Rate Guarantee	Rates for CCSB plans are guaranteed for 12 months from the effective date.

Reapplying for Covered Services After Notice of Coverage Cancellation	Employers may reapply after either voluntary termination or involuntary termination due to non-payment of monthly premiums. Employers seeking to reapply for coverage shall be considered a new group.
Guaranteed Issue	Employers and their employees who are eligible for CCSB are guaranteed coverage.
Health Reimbursement Arrangements or Other Employer Funded Arrangements	HRAs and other employer funding arrangements for employee cost share are subject to health and dental insurance company requirements as stated in their specific Group Service Agreements (GSAs) for CCSB policies.
Spouse Only Groups	Spouse-only groups are not eligible for covered services. An employer must have one common-law employee (who cannot be a spouse) who works at least 30 hours a week.
Reinstatements for Coverage After Notice of Coverage Cancellation	Terminated groups due to non-payment may request to be reinstated in the same coverage in which last enrolled within 30 days after the effective date of termination and all past-due payments must be made before reinstatement. The group may only reinstate once in 12 months beginning from the time of their original effective date or from their most recent renewal date, whichever is more recent.

Annual Special Enrollment Period	The Annual Special Enrollment Period for employers is Nov. 15th through Dec. 15th for a January 1st effective date. Groups not meeting participation or contribution requirements are allowed to enroll in CCSB during this special enrollment period every year. Groups must meet all other requirements.
Two-Life Groups with One Eligible Waiver	Two-life groups with one valid waiver are eligible for CCSB coverage. An employer must have one common-law employee (who cannot be a spouse) who works at least 30 hours a week.
Waiting Periods	Waiting periods are determined and monitored by the employer and must comply with applicable federal and state laws, including the California Insurance Code and the California Health and Safety Code. CCSB does not monitor waiting periods.
Waiving Waiting Periods	At the employer's discretion, waiting periods can be waived *only at initial* enrollment for new hires.
Discontinued Reference Plan	If an employer's reference plan is no longer available at renewal, the employer must select a new reference plan during the employer's annual election period. If the employer does not select a new reference plan before renewal quote creation, a default alternative reference plan will be auto selected for the group. However, the contribution rate applied to the new reference plan will remain as the previous employer contribution rate selected.

Employee Eligibility	
	Less than 20 Eligible Employees (EE): Employers with less than 20 EE's have the option to include Infertility benefits only on non-HMO health insurance plans If the Employer chooses to offer Infertility coverage the following applies: • Employees who select an HMO (A health insurance plan that covers

Infertility	only in-network care (except for emergencies) and need a referral to see a specialist.) product cannot select a health insurance planwith Infertility coverage. A PPO (A health insurance plan where you can get care from in-network or out-of-network providers without a referral (cost varies between in and out of network.) the product must be selected. If the Employer chooses benefits not to offer Infertility coverage, the following applies: • Employees electing an HMO, or PPO product cannot select a health insurance plan with Infertility benefits. • More than 20 EEs: Employers with more than 20 EE's have the option to include Infertility coverage on all health insurance plans or not to offer infertility coverage. If your employer has chosen to offer Infertility coverage, then all health insurance plans should include infertility coverage. • If your employer has chosen not to offer Infertility coverage, then the health insurance plans availableshall not include Infertility coverage
Dependent Children Age Max	Dependent children are eligible for coverage up to age 26. Notice of termination for child dependents who turn 26 is provided 90 days before the last day of coverage. Termination is effective the 1st day of the month following their 26th birthday.
Maximum Monthly Premiums for Dependents	When invoicing monthly premiums, which is your monthly payment to your health insurance company or creating group quotes, 3 is the maximum number of dependents under the age of 21 that will be charged a monthly premium in a single or two-parent family. Example: employee John Smith enrolls himself and his 6 dependent children, 4 of the children are under the age of 21, and 2 are over the age of 21. Applying the maximum monthly premium for dependents rule to his monthly premiums, John would only be invoiced for himself, 3 of his children under the age of 21, and both of his children over the age of 21, the 4th dependent under the age of 21 would not be invoiced.
Eligible Dependent(s)	Employers that wish to offer dependent coverage may do so for the following eligible dependent(s): • Spouse • Registered Domestic Partner • Non-registered Domestic Partner • Children (including adopted children, foster children, or those under legal guardianship) • Disabled Adult Children.
Families that Work for the Same Company	Family members who work for the same employer may enroll as a subscriber with dependents or separately, at their discretion. All eligibility requirements still apply.
Ineligible Employees	Employees who are not eligible for coverage in CCSB include: • 1099 employees • seasonal employees • temporary employees • Union employees (subject to collective bargaining) • Part-time with less than 20 hours per week

Maximum Enrollee Age	There is no maximum enrollee age for a subscriber; however, there is a maximum enrollee age for a dependent child, which is 25.
Medical Group/Independent Physician Association (IPA)Selection by Dependents	Each Health Plan Carrier determines if dependents can choose a different medical group/IPA than that chosen by the subscriber.
Newborn Policy	For the first 30 days of the newborn's life, he or she will be covered as an extension of the mother under her policy and deductible (The amount you pay before the health insurance company pays). Starting on the 31st day of the newborn's life, the baby will need to have his or her policy. Upon enrollment, the coverage effective date is the date of birth or the first day of the following month, at the parents' election.
Plan Selection Options for Employees and Dependents	Employees and their dependents must be enrolled in the same plan.
Monthly Premium Rates - Initial Group Enrollment and Renewal	Employees and their dependents will be rated at the age they are at the time of their initial group enrollment. Rates will not change until the annual group renewal. At renewal, rates will reflect enrollee ages as of the renewal date.
Retiree Coverage	Retiree coverage is not offered.
Employee's Discontinued plans	At renewal, if an employee's plan is discontinued, 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.
Special Enrollment Periods	After initial enrollment, health and dental insurance planchanges are submitted through the 15th day of the first coverage month and will be effective retroactively to the 1st of the current month unless otherwise requested. CCSB will process health and dental insurance plan changes submitted after the 15th day of the first coverage month for the 1st of the following month. Health and dental insurance plan changes made during the first 30 days of coverage must be with the same health and dental insurance company. For more information: Go to the Qualifying Life Events – Special Open Enrollment Window in the Covered California for Small Business Employer Guide at https://www.coveredca.com/pdfs/CCSB-Employer-Guide_2023.pdf
	Billing

Payment	Initial and ongoing payment must be the total amount due to CCSB. For new enrollment, membership is not effectuated until the initial payment is received and applied to the group's account.
Payment Grace Period	Health care monthly premiums are due before the month of coverage and must be postmarked by the last day of the invoicing month. If the invoice total amount due is not received by the end of the grace period, the employer will be notified that coverage will terminate at the end of the grace period. The participating employer is responsible for notifying employees if coverage lapses. A period of 30 days will be allowed for payment of any monthly premium due after the initial monthly payment. If less than the total amount due is paid within that period, coverage will terminate at the end of the grace period. The employer will be notified of the grace period and effective date of termination.
Monthly Payment Options for Invoices	Monthly Payments can be made via online payments, checks, cashier's checks, or money order and made payable to Covered CA CCSB or Covered CA Small Business. **Please send payment to the Payment Mailing Address:** **Covered California for Small Business** **PO Box 74016** **Los Angeles, CA 90074-0167** **Overnight Payment Mailing Address:** **Bank of America Lockbox Services** **Lockbox LAC-740167** **2706 Media Center Drive** **Los Angeles, CA 90065**
Non-Sufficient Fee (NSF)	For a monthly payment that is returned unpaid for any reason, CCSB shall apply a $25.00 insufficient funds fee. If a second monthly payment is returned unpaid for any reason within six months of the prior returned monthly payment, the employer shall submit payment and the insufficient funds fee for the returned monthly payment in the form of a cashier's check or money order. This requirement to make monthly payments in the form of a cashier's check or money order shall continue for 12 months beginning with the first month following the last paid-through date.
Rate Verification	For new group enrollment, the final rates will be reflected on the first monthly payment. invoice.

Out of State plans and guidelines	
Percentage of Out of State Employees Allowed	Small employers eligible for coverage in CCSB must have the majority of their employees employed within California (employed at a California worksite).
Multi-State Groups	Employers may participate in multiple SHOPs if the employer offers coverage to employees whose primary work site is in the SHOP service area. Employers must submit a completed application, and all required documentation required of CA- domiciled employers. Health and dental Insurance company availability and rates will be tied to the CA worksite address where most of the employer's employees work.
Out of State plans	Blue Shield PPO (A health insurance plan where you can get care from in-network or out-of-network providers without a referral (cost varies between in and out of network). For (all metal tiers -coverage levels such as bronze, silver, gold, or platinum) are available for out-of-state employees.
Out of State Rates and Locations	Out-of-state employee rates and health and dental insurance company availability are based on the employers. California principal business address location.

Valid Waiver	
Valid Waiver	Employees hold valid waivers if they have: • Coverage through an employer-sponsored health and dental Insurance company • Coverage by Tricare • Coverage by Medicare • Coverage by Medi-Cal • Coverage by Medicaid • Coverage that meets the definition of" minimum essential coverage." • Coverage by any other federal or state health coverage program. • Employees who waive coverage in CCSB are not eligible for Financial Help to Lower Your Monthly Premium Payment.
Dental Coverage	
Children's Dental Age Maximum	Dependent children are eligible for Children's Dental coverage up to age 19. Coverage is terminated on the 1st of the month following their 19th birthday. If a dependent child ages out of Children's Dental and loses dental coverage, it will be considered as a qualifying event for the dependent child only. The dependent child may choose to enroll in a family dental plan.
Children's Dental Coverage for Child Dependents	Child dependents (up to the age of 19) can enroll in Children's Dental coverage at the employee's discretion.
Qualifying Event	Losing another dental coverage is a qualifying event to add dental during a plan year for both the employee and dependent.
When Dental can be added	Eligible employees and dependents may add a dental plan during the plan year if they experience a qualifying life event or during their annual open enrollment period.
Dental Reference Plan & Dental Contribution	If an employer elects to choose dental for their employees and dependents, then they must select a dental reference plan. The reference plan is the plan employers choose to determine the amount the employer will contribute towards their employee premiums. An employer has the option to elect to contribute towards their employees' dental premiums, however, it is not a requirement for coverage.