COMMUNITY CARE HEALTH

Small Group - Employer Application

Effective Date (mm/dd/yyyy) _____

Email application to your Community Care Health representative or your broker.

1: COMPANY INFORMATION

Company name :_____

Doing business as (DBA): _____ Website: _____

Type of company: ☐Corporation ☐Sole proprietorship ☐Partnership ☐Limited liability company (LLC) ☐Other: _____

In business since (mm/dd/yyyy)_____ Federal tax ID (EIN) number_____SIC code (4 digits)_____

Physical street address (no P.O. boxes) _____

City: _____ State: _____ ZIP:_____ County _____

Phone: _____ Fax: _____

All employees must be covered by workers' compensation, unless not required to be covered by law. You're not eligible to apply for coverage if you don't have workers' compensation, unless you're exempt. I attest that the following information is correct.

☐ Yes, my company has workers' compensation. ☐Pending

If Yes or Pending, name of carrier: _____Policy#_____

(Indicate "unknown" or "pending" as applicable)

☐ Exempt from providing workers' compensation for the following reason: _____

2A: EMPLOYER ELIGIBILITY

In determining the number of employees or eligible employees, affiliated companies that are eligible to file a combined tax return for purposes of state taxation shall be considered 1 employer and must apply as 1 employer.

Is your company affiliated with another company and eligible to file a combined tax return? ☐ Yes ☐ No

2B: EMPLOYEE COUNT

Please provide the total number of employees (full-time and part-time).

Total _____ Authorized company signer's initials _____

Note: If the total number of employees noted above is 100 or fewer, skip the following and go to section 2C.

If your total number of employees noted above is more than 100, please provide the total number of full-time and full-time-equivalent employees on the line below. For information on calculating the number of full-time and full-time-equivalent employees (FTE), refer to the California Small Group Law (1357.500)(k)(3) or your legal counsel. To qualify for small group coverage, your company must have at least 1 but no more than 100 full-time and full-time-equivalent employees on at least 50% of the previous calendar quarter or previous calendar year. For purposes of determining whether an employer has one employee, sole proprietors and their spouses, and partners of a partnership and their spouses, are not employees.

Total _____ Authorized company signer's initials _____

2C: ELIGIBLE EMPLOYEES

Please provide the total number of eligible employees.

Total _____ Authorized company signer's initials _____

COMMUNITY CARE HEALTH

Small Group - Employer Application

Company name (please print)

_____

3: CONTINUATION COVERAGE[1]

What type of continuation coverage is your company subject to? ☐ Federal COBRA (20+ employees) ☐ Cal-COBRA (2-19 employees)

Are you submitting COBRA applications? ☐ **Yes** ☐ **No**

For Cal-COBRA applications, contact our Member Service Contact Center at 1-855-343-2247.

4: COMPANY PREMIUM CONTRIBUTION

Company contribution for employee coverage

Your contribution to employee coverage can be a percentage or a fixed dollar amount. Your minimum contribution must be at least 50% of the employee's premium for the lowest-priced Community Care Health medical plan offered by you, the employer.

Company contribution for employees: $ _____ or _____ % of premium

Company contribution for dependent coverage

If you have 50 or more full-time or full-time-equivalent employees, you must offer dependent coverage.[2] Dependent coverage is optional for groups with 49 or fewer employees. **You don't have to contribute to dependent coverage.**

Are you offering dependent coverage? **(Check yes if you're offering coverage even if you aren't contributing.)** ☐ **Yes** ☐ **No**

Company contribution for dependents: $ _____ or _____ % of premium **(enter "0" if you're offering but not contributing to dependent coverage.)**

5: WAITING PERIOD FOR NEW EMPLOYEES

Select one of the following:

☐ First of the month after date of hire

☐ First of the month following one month from the date of hire

☐ First of the month following two months from the date of hire, not to exceed 90 days

6: OTHER MEDICAL COVERAGE

Does your company currently have active group health coverage? ☐ **Yes** ☐ **No**

Name of carrier: _____ Renewal date: _____

Will you be offering another carrier's small group health plan, alongside CCH, to your employees? ☐ **Yes** ☐ **No**

Name of carrier: _____ Number of employees enrolled: _____

7: ERISA STATUS

Is your company subject to ERISA?[3] ☐ **Yes** ☐ **No** If you don't select an answer, we'll record your status as *Yes*.

COMMUNITY CARE HEALTH

Small Group - Employer Application

Company name (please print) _____

8: CONTRACT SIGNER INFORMATION

There is only 1 contract signer. This principal person is responsible for signing the group agreement, providing renewal information, and authorized to make membership or contractual changes to your account.

First name _____ MI _____ Last name _____

Street address (no P.O. boxes) _____ City _____ State _____ ZIP _____

Office phone _____ Ext. _____ Fax _____ Cell phone _____

Email _____ How should we correspond with this person? (Select 1 only)

☐ Email ☐ Fax ☐ Mail

9: BILLING CONTACT INFORMATION

The billing contact is the person within your company to whom billing statements are addressed. This person will have access to group information, but isn't authorized to sign the group agreement or to make contractual changes to your account. Only 1 billing contact is allowed. If you're using a Third-Party

Administrator (TPA), including a broker acting as a TPA for billing administration, please skip the following and proceed to section 10.

☐ **Check here if same as contract signer.**

First name _____ MI _____ Last name _____

☐ Check here if this person is also authorized to make changes to your contract.

Street address _____ City _____ State _____ ZIP _____

Office phone _____ Ext. _____ Fax _____ Cell phone _____

Email _____ How should we correspond with this person? (Select 1 only)

☐ Email ☐ Fax ☐ Mail

10: THIRD-PARTY ADMINISTRATOR (TPA) CONTACT INFORMATION

The TPA contact is an external person, company, or broker that's contracted for the purpose of administering the group's billing and enrollment or solely administering your COBRA benefits. This person will have access to group information, but isn't authorized to sign the group agreement or to make contractual changes to your account.

TPA company name _____

Will a TPA, including a broker, administer Federal COBRA? ☐ **Yes** ☐ **No** ☐ Check here if COBRA statement will be sent to group's billing address.

First name _____ MI _____ Last name _____

Street address _____ City _____ State _____ ZIP _____

Office phone _____ Ext. _____ Fax _____ Cell phone _____

Email _____ How should we correspond with this person? (Select 1 only)

☐ Email ☐ Fax ☐ Mail

11: INTERESTED PARTY CONTACT INFORMATION

An interested party is an individual authorized to access your group's information, such as enrollees, premium contributions, and plan selections. An interested party may also be authorized to make changes to your contract, such as adding/deleting plans, adding/deleting employees, or increasing/decreasing company premium contributions.

First name _____ MI _____ Last name _____

☐ Check here if this person is also authorized to make changes to your contract.

Street address_____ City_____ State _____ ZIP _____

Office phone_____ Ext. _____ Fax _____ Cell phone_____

Email_____ How should we correspond with this person? (Select 1 only)

☐ Email ☐ Fax ☐ Mail

ADDITIONAL INTERESTED PARTY

First name _____ MI _____ Last name _____

☐ Check here if this person is also authorized to make changes to your contract.

Street address_____ City_____ State _____ ZIP _____

Office phone_____ Ext. _____ Fax _____ Cell phone_____

Email_____ How should we correspond with this person? (Select 1 only)

☐ Email ☐ Fax ☐ Mail

12: AUTHORIZED AGENT/BROKER OF RECORD FOR COMMUNITY CARE HEALTH

To be completed by your Community Care Health-appointed agent/broker after completion of this application. If you're a broker who hasn't registered as a firm or agent with Community Care Health, please call the Community Care Health customer service at 1-855-343-2247.

Notice to agent or broker:
If you've assisted the applicant in submitting this application, the law requires that you attest to this assistance. If, in making this attestation, you state as true any material fact you know to be false, you'll be subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code section 1389.S(c) or Insurance Code section 10119.3, in addition to any other applicable penalties or remedies under current law.

You must select Yes or No:
I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

☐ **Yes** ☐ **No**

Agent name _____ License number _____

Office phone_____ Fax _____ Cell phone _____

Email_____

Firm name _____ Community Care Health broker firm ID _____

Street address_____ City_____ State _____ ZIP _____

Agent/broker signature Date

X _____ _____

COMMUNITY CARE HEALTH

Small Group - Employer Application

Company name (please print)

_____

13: MEDICAL PLANS

Please select the plan(s) you'd like to offer. For more information on the plans listed below, contact your sales representative or agent/broker.

HMO

- ☐ Bronze 60 HDHP HMO 7000/0
- ☐ Bronze 60 HMO 6300/65*
- ☐ Silver 70 HMO 2250/50*
- ☐ Silver 70 HDHP HMO 2700/25
- ☐ Silver 70 HMO HRA 2250/50*
- ☐ Gold 80 HMO 250/35
- ☐ Gold 80 HMO HRA 2150/35*
- ☐ Gold 80 HMO 500/35*
- ☐ Gold 80 HMO 750/30*
- ☐ Gold 80 HMO 1000/35*
- ☐ Platinum 90 HMO 0/10/500*
- ☐ Platinum 90 HMO 0/25*
- ☐ Platinum 90 HMO 0/10/250*
- ☐ Platinum 90 HMO 0/20

EPO

- ☐ Silver 70 EPO 1500/50*
- ☐ Silver 70 HDHP EPO 2850/20*
- ☐ Gold 80 EPO 250/30*
- ☐ Gold 80 EPO 500/30*
- ☐ Gold 80 EPO 750/30*
- ☐ Gold 80 EPO 1500/35*
- ☐ Platinum 90 EPO 0/15*
- ☐ Platinum 90 EPO 0/25*

*Chiropractic benefits are included with these plans.

HDHP plans are HSA-qualified. If you've selected an HDHP or HRA medical plan above, please indicate if you'd also like Community Care Health to administer your HSA or HRA health payment account. If you select Yes, a Community Care Health representative will contact you to provide more information on your next steps, as additional documents and administrative fees apply.

HSA administered through CCH? ☐ **Yes** ☐ **No** **HRA administered through CCH?** ☐ **Yes** ☐ **No**

To help you make an informed choice, Summary of Benefits and Coverage (SBC) documents for all our plans are available at **communitycarehealth.org**. SBCs summarize important information about our health coverage options in a standard format, so you can easily compare benefits and coverage offered by Community Care Health and other carriers.

14: VISION PLANS

VISION PLAN CHOICES:

☐ **Plan 1**: 12/12/12 ☐ **Plan 2**: 12/12/24 ☐ **Plan 3**: 12/24/24 ☐ Decline Coverage

Frame and Contact Lens Allowance: ☐ $120 ☐ $130 ☐ $150

EMPLOYER CONTRIBUTION:

☐ Voluntary ☐ Employer Paid

VISION[4] COVERAGE:

The Employer has current vision coverage for Employees? ☐ **Yes** ☐ **No**

If Yes, please complete the following:

Name of carrier: _____ Policy #: _____ Carrier Phone: _____

15: INFERTILITY BENEFIT

The optional infertility benefit is available only to groups with 20 or more eligible employees where Community Care Health is the sole carrier. If you select this benefit, it'll be added to all the HMO plans you offer and the cost will be included in the medical plan rate.

☐ Add infertility benefit

16: IMPORTANT INFORMATION - PLEASE READ CAREFULLY

This is an application for coverage only. No contract for coverage will exist until Community Care Health has completed its review and communicated to the business applicant or the applicant's broker that the application has been accepted and a group health plan contract/group policy will be issued.

All groups may be subject to a recertification process. Recertification is done to ensure that groups meet all Community Care Health requirements and those set forth in the California Health and Safety Code and the Affordable Care Act.

Notice: California law prohibits an HIV test from being required or used by health care service plans/health insurance companies as a condition of obtaining coverage/health insurance coverage.

17: FOOTNOTE INFORMATION

[1] The employer retains all COBRA administrative responsibilities (such as notifying qualified beneficiaries of COBRA rights and processing COBRA elections) but delegates to Community Care Health, the following clerical functions: billing Cal-COBRA members for applicable premiums (the employer authorizes Health Plan to add an administrative charge for this service), and terminating Cal-COBRA members for nonpayment of Cal-COBRA premiums or for expiration of the expected time limit that the employer specifies for Cal-COBRA coverage. If you use a Third-Party Administrator (TPA), please contact your Community Care Health representative.

[2] For more information about Employer Shared Responsibility, see section 4980(H)(C)(2) of the Internal Revenue Code.

[3] ERISA is a federal law that sets minimum standards for employee benefit plans established by private employers and employee organizations. Many group health plans are subject to ERISA, although government and church plans generally are not. If you're unsure of your group health plan's ERISA status, we recommend that you consult with your financial or legal advisor before responding.

[4] Vision plans are available only when purchased with a medical plan. If you choose an employer paid vision plan, all eligible subscribers and dependents must participate.

18: SIGNATURE

As a company principal/corporate officer, having authority to contract with Community Care Health, I agree that:

- Prepaid monthly premiums will be posted to Community Care Health's account by the due date on the Community Care Health billing statement.
- My company will use employee enrollment application forms provided or approved by Community Care Health for new employees.
- The eligibility data provided by my company to Community Care Health will include coverage effective dates for my company's employees in compliance with the waiting period requirement in the Affordable Care Act and federal regulations, which require that waiting periods may not exceed 90 days. My company acknowledges that the effective date of coverage for new employees and their eligible family dependents will be on the 1st of the month and won't exceed the waiting period established by my company.
- My company will abide by the contract provisions.

I've read, understood, and agreed to Community Care Health's Small Business Guidelines, which may be included with my rate quote or, if not included, is available at **communitycarehealth.org**.

I attest that my company meets the definition of "small employer" as defined by applicable federal and state law. I have a minimum of 1 W-2 employee (excluding the owner, spouse, or legal domestic partner) and attest that at least 70% of eligible employees are covered by group coverage.

I understand that a Summary of Benefits and Coverage (SBC) for each of my medical plans is available at **communitycarehealth.org**. I agree to provide my eligible employees with SBCs for any plan(s) I've chosen or change to in the future.

I certify, to the best of my knowledge, that all of the responses given are true, correct, and complete. I understand that if I performed an act or practice constituting fraud or made an intentional misrepresentation of material fact, any coverage approved by Community Care Health may be canceled or the applicable premiums/rates may be adjusted.

I understand that if Community Care Health intends to rescind or terminate my coverage, I'll be sent a notice via regular certified mail at least 30 days prior to the effective date of the rescission or termination explaining the reasons for the intended rescission or termination and notifying me of my right to appeal that decision to the Department of Managed Health Care director. I understand that after 24 months following the issuance of my Community Care Health health plan contract/Community Care Health health insurance policy, Community Care Health shall not rescind my plan contract/policy for any reason, and shall not cancel my plan contract/policy, limit any of the provisions of my plan contract/policy, or raise premiums on my plan contract/policy due to any omissions, misrepresentations, or inaccuracies in the application form, whether willful or not.

COMMUNITY CARE HEALTH ARBITRATION AGREEMENT*

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Community Care Health, any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Community Care Health, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

_____ _____

Authorized company signer (please print name) Title (please print)

X _____ _____

Signature Date