EMPLOYER ADMINISTRATIVE GUIDE

CaliforniaChoice®
Your Health. Your Choice.®

Samantha Siders
Small Business Owner
*and **CaliforniaChoice** Member*

A SEQUENCE MASTER
A MOM
A LEADER

I AM CALIFORNIA DIFFERENT®

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SHARP Health Plan
Sutter Health Plus
Your Health Plan
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Groups Beginning 4/1/22

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Welcome To CaliforniaChoice®

We're proud to be a part of your health program!

During the coming coverage year, it's inevitable that you'll be presented with a question or situation that needs clarification. This Employer Administrative Guide is intended to guide you through different administrative procedures, as well as answer general questions about the CaliforniaChoice program. Please feel free to call our Customer Service Center at **800.558.8003** if you need further assistance.

Although your application for coverage and monthly billing are processed by CaliforniaChoice, the Group Service Agreement (contract) for your health coverage is with each of the applicable Health Plans in the CaliforniaChoice program. Group Service Agreements from each participating Health Plan are available after log-in on **calchoice.com**. Some of the Agreements may require your signature. The Agreements should be retained with this Employer Administrative Guide for future reference.

Each plan offered in the CaliforniaChoice Program meets the requirements of the Affordable Care Act (ACA).

Keep In A Safe Place

Contact Information for Employers and Employees

CaliforniaChoice® Customer Service	Health Plan and Ancillary Carrier Customer Service
(800) 558-8003	**See phone numbers below**
Our Customer Service team will assist Employers and Employees with: • Administrative topics • ID Card requests • Verification of enrollment • Benefits • Evidence of Coverage documents	The Health Plan or Ancillary Carrier will assist Employees with: • Changes to Primary Care Physician (PCP) • Claims • Grievances/Issues related to Provider Service • ID Card requests • Verification of enrollment • Benefits • Evidence of Coverage documents

HMO Health Plans

Anthem Blue Cross 855.383.7248
English/Español, Mon-Fri 8:30 a.m. - 7:00 p.m.

Health Net.....800.361.3366
English/Español, Mon-Fri 8:30 a.m. - 5:00 p.m.

Kaiser Permanente
English 800.464.4000
Español.....800.788.0616
7 days a week 7:00 a.m. - 7:00 p.m.

Sharp Health Plan.....800.359.2002
English/Español, Mon-Fri 8:00 a.m. - 5:00 p.m.

Sutter Health Plus.....855.315.5800
English/Español, Mon-Fri 8:00 a.m. - 7:00 p.m.

UnitedHealthcare 800.624.8822
English/Español, Mon-Fri 8:00 a.m. - 9:00 p.m.

Western Health Advantage..888.563.2250
English/Español, Mon-Fri 8:00 a.m. - 5:00 p.m.

EPO Health Plan

Cigna + Oscar.....855.672.2789
English, Mon-Fri 8:00 a.m. - 8:00 p.m.;
Sat-Sun 9:00 a.m. - 5:00 p.m.

PPO Health Plan

Anthem Blue Cross 855.383.7248
English/Español, Mon-Fri 8:30 a.m. - 7:00 p.m.

Dental Ancillary Carriers

Ameritas 877.203.0036
English/Español, Mon-Thurs 5:00 a.m. - 10:00 p.m.;
Fri 5:00 a.m. - 4:30 p.m.

Dentegra® Smile Club.....877.280.4204
English/Español, Mon-Fri 4:15 a.m. - 5:00 p.m.

MetLife & SmileSaver℠.....800.880.1800
English/Español, Mon-Fri 8:00 a.m. - 5:00 p.m.

Vision Ancillary Carriers

EyeMed Voluntary Vision.....866.299.1358
English/Español, Mon-Fri 8:00 a.m. - 6:00 p.m.

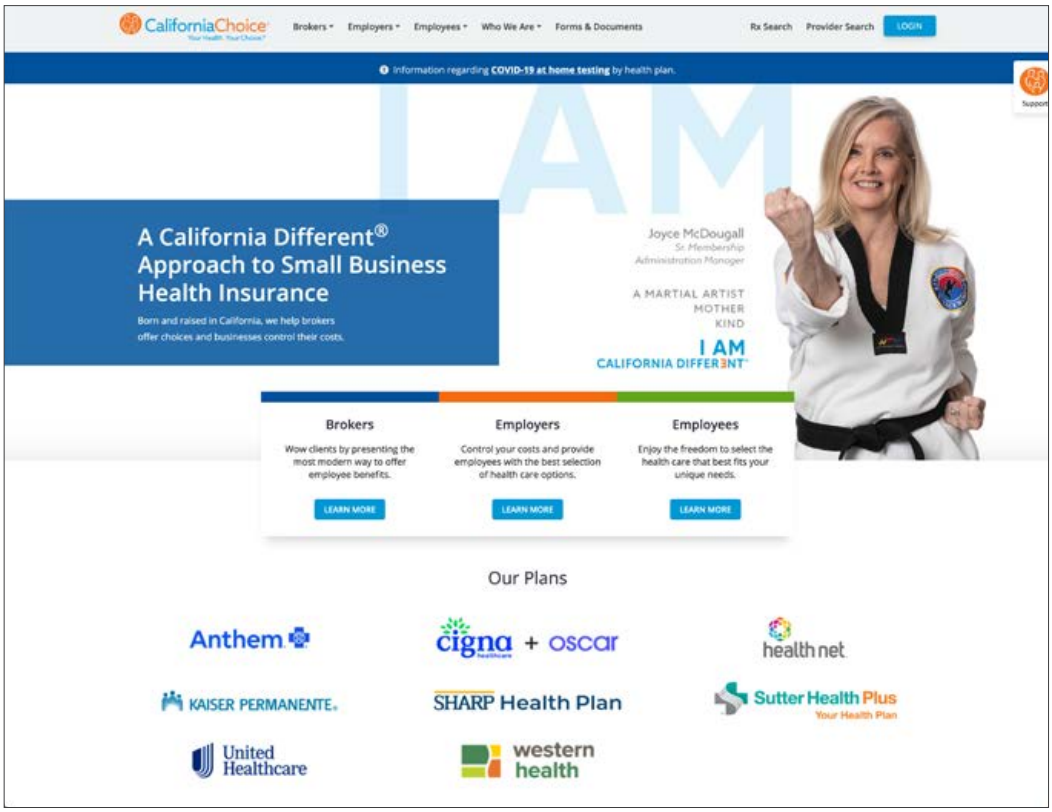
EyeMed Vision
Discount Program.....866.723.0391
English/Español, Mon-Fri 8:00 a.m. - 6:00 p.m.

VSP Voluntary Vision 800.877.7195
English/Español, Mon-Fri 5:00 a.m. - 7:00 p.m.;
Sat 6:00 a.m. - 2:30 p.m.

Chiropractic/Acupuncture Ancillary Carrier

Landmark Healthplan 800.298.4875
English/Español, Mon-Fri 5:00 a.m. - 5:30 p.m.

Find what you need fast at calchoice.com



Access forms, directories, Doctor/Rx search, and plan information 24/7. Complete up-to-date information is just a click away.

Please be advised that some forms and written communications are available on our website in the following languages: Chinese, Korean, Russian, Spanish, Tagalog, and Vietnamese. Employees can register their applicable, Plan-specific preferred language by completing the Language Assistance Preference Form, also found on our website **calchoice.com**.

Top Coverage Issues

Most service problems experienced by employees can be easily avoided with a little preventive attention. Here are the most commonly overlooked items that can cause delays or coverage lapses:

- Unsigned Applications or Change Request Forms
- Forgetting to add newborns/new spouses to coverage
- Omitting information on forms, such as date of full-time employment, date of birth, etc.
- Not selecting a health plan/benefit level
- Not selecting a Primary Care Physician (PCP)
- Not electing dependent coverage
- Not completing a waiver for dependents
- Not ensuring that checkboxes are clearly marked on forms
- Not using the proper forms

Coverage Eligibility Requirements

Group

CaliforniaChoice® benefits are offered exclusively to small businesses with up to 100 full-time, eligible employees. However, businesses with more than 100 employees may be eligible if they had less than 100 full-time, eligible employees for 50% of its working days during the preceding calendar quarter or preceding calendar year.

- 1 - 2 Employees: 100% of all employees. All groups must include at least one medical enrolled in CaliforniaChoice employee who is not a business owner or spouse/domestic partner of business owner.
- 3 - 100 Employees: 70% of eligible employees enrolling in CaliforniaChoice medical coverage.
- Home Office must be in California (principal executive office).
- 51% of your eligible employees must reside in California.
- You must have a valid Federal Tax ID Number (not a Social Security Number).
- You must have active Worker's Compensation Coverage.
- Employees must be permanent and actively working an average of 30+ hours per week over the course of a month, at the small employer's regular place of business or 20+ hours per normal work week for at least 50% of the weeks in the previous calendar quarter. Applicable documentation will be requested to verify employee eligibility (such as a Quarterly Wage Report).

Employee

Four conditions must be met for an employee to gain and keep coverage. Every employee must:

1. **Meet the employer's selected waiting period**
2. **Be permanent and actively working an average of 30+ hours per week over the course of a month, at the small employer's regular place of business or 20+ hours per normal work week for at least 50% of the weeks in the previous calendar quarter**
3. **Be a permanent employee who is not eligible for medical healthcare coverage offered by or through a labor union**
4. **Be paid on a salary/hourly basis (not 1099, commissioned or substitute)**

Administration Basics

New Hire Enrollment

Benefit eligibility is based on the completion of the waiting period by new employees. Employers may request a New Hire Enrollment Quote Request for new employees at any time. Along with this guide, your employer packet includes New Hire Enrollment Quote Request Forms and Employee Enrollment Applications.

Enrolling a New Hire is Easy:

- Complete the **New Hire Enrollment Quote Request** form and **fax** it to 714.953.4097 to obtain a customized enrollment quote for new employees. The enrollment quote will be returned to your attention within a few days, along with a Member Enrollment Guide and Employee Enrollment Application.
- For an immediate quote, visit our website at: **calchoice.com**, login, select "Employees" and "New Hire Quote."
- Employees who wish to obtain coverage through CaliforniaChoice® must complete the **Employee Enrollment Application**.
- Employers should provide their group number in the top section of the front page of the application.
- The employer can **e-mail**, **fax** or **mail** the original to CaliforniaChoice as soon as possible, but no more than 90 days prior or 30 days after the employee's effective date of coverage (please retain a copy of the completed application for your records).

  Fax: 714.558.8000
  Mail: CaliforniaChoice
  721 South Parker, Suite 140
  Orange, CA 92868
  E-mail: memberprocessing@calchoice.com

- Coverage for new employees and their dependents will be effective on the first day of the month **following** the completion of the group's waiting period, not to exceed 90 days from the date of hire.
- New employees will be mailed one or more information packets to their residence which will include ID card(s); a description of their selected benefit plans; and instructions on how to use the plans.

Note: Please contact CaliforniaChoice Customer Service Center within 7 business days to confirm receipt of all mailed items.

Example:

Jane was hired on **March 2nd**. The group has a 60-day waiting period. Jane will complete the waiting period on April 30th. Jane's effective date will be May 1st.

Example:

Jane was hired on **March 5th**. The group has a 60-day waiting period. Jane will complete the waiting period on May 3rd. Jane's effective date will be June 1st to ensure the waiting period does not exceed 90 days.

Important

Waiving Coverage: It is extremely important that employees wishing to waive coverage **complete the CaliforniaChoice Medical / Dental Waiver** portion of the Employee Enrollment Application advising them of their legal rights. Pursuant to the Knox Keene Act, Section 1357(d)(4)(A), employees wishing to waive coverage **must execute a written waiver** and **Employers are required to maintain that waiver on file**. Waivers may also be submitted to CaliforniaChoice via fax at 714.558.8000 for retention in our files.

Should the employee seek coverage after their eligibility period and the employer failed to obtain the waiver, the **Employer may be held liable** for the cost of healthcare services the Employee later incurs.

Life Insurance: When employers offer life insurance, ALL employees considered eligible for medical coverage must enroll in life insurance coverage even if they do not wish to enroll in medical or dental coverage through CaliforniaChoice. Please have each employee complete the Employee Enrollment Application for life insurance coverage.

Administration Basics *(continued)*

Late Enrollee

CaliforniaChoice® will allow adding an employee and/or dependents*** other than during Renewal IF the:

1. **Employee/dependents had previously waived enrollment* due to other coverage in force but lost that coverage.** Loss of coverage must result from circumstances beyond the individual's control.

2. **Employee/dependents declined to enroll previously* due to other coverage in force** and Employer contributions toward that coverage have been exhausted or dramatically reduced.

3. **Employee declined to enroll previously*** but then experienced a change in family status (i.e., employee got married, entered into a domestic partnership, gave birth, adopted a child, or established a parent-child relationship).

**Submitted medical/dental waiver.*

How to Obtain Coverage as a Late Enrollee

Employees must provide the following documentation and submit each item to CaliforniaChoice **within 60 days of change in family status or loss of coverage:**

- An **Employee Enrollment Application** (for employee and dependents)
- A **Change Request Form** (dependents only)
- Proof of loss of other coverage (i.e., HIPAA Certificate)
- Proof of change in family status (i.e., marriage certificate, Declaration of Domestic Partnership**, birth certificate, legal adoption documentation)

Coverage will be effective as follows:

Change of Family Status

Marriage/Domestic Partnership/Stepchild — If all required documentation is received before the 16th day of the month of marriage/establishment of domestic partnership, premiums are charged for the full month and coverage begins on the date of marriage/establishment of domestic partnership. If all required documentation is received on or after the 16th day of the month of marriage/establishment of domestic partnership, coverage begins on the 1st of the month following the date of receipt.

Birth, Adoption, Legal Guardianship, Eligible Dependent Child — If birth/date of placement occurred before the 16th of the month, coverage begins on 1st day of the month of the date of their birth/placement. If birth/date of placement occurred on the 16th or after, child is automatically covered at no cost under Subscriber between date of birth/placement and the 1st of the following month. Coverage for the dependent begins on the 1st of the month following the birth/date of placement.

*** If domestic partners have filed a Declaration of Domestic Partnership and have not yet received a copy from the state, a signed Affidavit of Domestic Partnership will be accepted. Domestic Partners agree to provide a copy of the Declaration of Domestic Partnership within 60 days of issuance. NOTE: There will be some benefit restrictions for Ameritas Dental PPO 3000, 3500, 4000 and 5000.*

**** Employee must be enrolled on coverage to enroll dependent(s).*

Administration Basics *(continued)*

Rehires

A former employee who has been rehired may be eligible for re-enrollment without completing the waiting period if he or she meets the following criteria:

- Employee previously completed your company's waiting period
- Employee has been rehired within six months of leaving the company
- Rehired employees have the same enrollment options as new hires

An Employee Enrollment Application must be received within **60 days** of the employee's return to work, accompanied by a written request to waive the waiting period and proof of full-time employment. Coverage will be effective first of the month following the rehire date.

Please Note: If the employee does not meet the criteria indicated on the left, then coverage will become effective first of the month following completion of the company's waiting period.

Return from Military Leave or California National Guard

An employee who was previously covered under the plan and has returned from Military Leave or California National Guard will be allowed to re-enroll into coverage without completing the waiting period. An Employee Enrollment Application must be received within 60 days of the employee's return to work, accompanied by a written request to waive the waiting period and proof of full-time employment. Coverage will be effective first of the month following the date of return.

Administration Basics *(continued)*

Voluntary Termination—Employees

An employee may choose to voluntarily withdraw coverage for themselves and/or their dependents by completing and submitting a **Change Request Form** to CaliforniaChoice®. The request must be received within 30 days from the date the Change Request Form was signed. **The request will become effective the last day of the month following receipt of the form by CaliforniaChoice**. This type of request will not be processed retroactively. The employee will be ineligible for re-enrollment until the Renewal period.

Involuntary Termination—Employees

All employees who become ineligible for group coverage must be terminated from the group plan. Employers must complete an **Employee Termination Notification Form**, and submit to CaliforniaChoice within 30 days from the last day employed.

Cal-COBRA law requires you, as the employer, to notify CaliforniaChoice of all employee terminations within 30 days from their last day employed.

Coverage will cease at the end of the month following the last day employed, for the employee and his/her dependents.

3 Ways to Notify CaliforniaChoice of an Employee Termination:

For your convenience, you may notify CaliforniaChoice of an employee termination by using one of these methods:

1. Faxing or e-mailing completed **Employee Termination Notification Form*** to the CaliforniaChoice Member Processing Center:

   Fax: 714.558.8000
   E-mail: memberprocessing@calchoice.com

2. Completing the **Employee Termination Notification Form*** on the back of the premium statement of your invoice and returning with your premium payment. (Retain a copy for your records.)

3. By visiting our website at: **calchoice.com**

<P.S.>

Please review the invoice received immediately following your request to terminate an employee to ensure that you are no longer being billed for that employee. If employee and premium appear, please contact the CaliforniaChoice Customer Service Center at 800.558.8003 for immediate assistance.

Please **DO NOT** send notification of an employee termination until after the last day of employment. Termination requests made prior to the last day employed cannot be processed. Also, please DO NOT self-adjust your billing statement. PAYMENT, as billed, will need to be MADE IN FULL. CaliforniaChoice will credit premium on the billing statement that follows the processing of the termination.

** Form must be signed and dated by an authorized group contact on file within CaliforniaChoice in order for the termination request to be processed.*

Understanding Your Benefit Choices

Comparison of HMO, EPO, and PPO benefits

HMO Benefit Plan

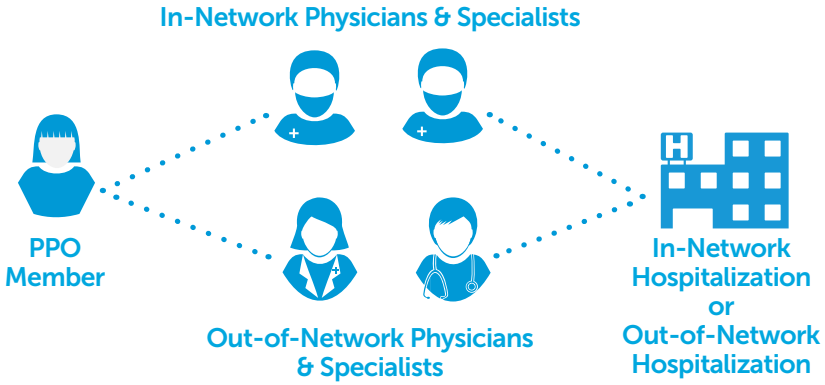
Under an HMO plan, all access to specialist and hospitalization must be facilitated through the member's Primary Care Physician (PCP).

EPO Benefit Plan

Under an EPO plan, members do not choose a Primary Care Physician (PCP). EPO members can receive their care from any of the in-network doctors and self-refer to in-network specialists.

PPO Benefit Plan

Under a PPO plan, members do not choose a Primary Care Physician (PCP). PPO members may self-refer to specialists. Members can receive care from 2 levels of in-network doctors or go out-of-network for lower benefits.



Family Coverage

Employee must be enrolled in coverage to enroll dependent(s).

Who can be covered?	Effective dates	Requirements that MUST be met:
New Spouse/ New Stepchild	During Initial Enrollment or Group's Annual Renewal: Coverage begins on group's effective date. Involuntary Loss of Other Coverage: Spouse can be added outside of Renewal only if he/she loses other coverage involuntarily. Coverage is effective the first of following month. Mid-Year Addition: Mid-year additions of a spouse will require a state-stamped copy of the Marriage Certificate. If the married parties have not yet received the state-stamped copy of the Marriage Certificate, a county issued receipt displaying the names of the parties and the date of marriage may be acceptable. Married parties agree to provide a copy of the state-stamped Marriage Certificate within 60 days of issuance. If all required documentation is received before the 16th day of the month in which the marriage was established, premiums are charged for the full month and coverage begins on the date of the event. If all required documentation is received on or after the 16th day of the month, coverage begins on the 1st of the month following the date of receipt.	• New spouse must be legally married to the employee, copy of marriage certificate required • New stepchild must also meet the dependent children requirements listed in the following sections

Family Coverage *(continued)*

Who can be covered?	Effective dates	Requirements that MUST be met:
Birth/Adoption/ Legal Guardianship/ Eligible Dependent Child	If birth/date of placement occurred before the 16th of the month, premium is charged for the full month and coverage begins on 1st day of the month of the date of their birth/placement. If birth/date of placement occurred on the 16th or after, child is automatically covered at no cost under Subscriber between date of birth/placement and the 1st of the following month. Coverage for the dependent begins on the 1st of the month following the birth/date of placement.	MEDICAL, CHIRO, VISION and **METTLIFE & SMILESAVER** DENTAL Dependent eligibility: • Born to, a step-child or legal ward of, adopted by, or have an established parent-child relationship with the eligible employee, employee spouse or domestic partner • Under age 26 (unless disabled, disability diagnosed prior to age 26) **AMERITAS** DENTAL Dependent eligibility: • Born to, a step-child or legal ward of, adopted by, or have an established parent-child relationship with the eligible employee, employee spouse or domestic partner • Financially dependent upon the employee per IRS guidelines • Unmarried or not involved in a domestic partnership • Under age 26 (unless disabled, disability diagnosed prior to age 26) **Disabled Dependents:** Dependents who are incapable of self-support because of continuous mental or physical disability that existed before the age limit of 26 are eligible for coverage until the incapacity ends. Documentation of disability will be requested. Once the child reaches the age limit of 26 for coverage, verification of eligibility will occur no more frequently than annually, at the child's birthday. **Dependents must meet all requirements listed in order to be eligible for enrollment**

Family Coverage *(continued)*

Who can be covered?	Effective dates	Requirements that MUST be met:
Domestic Partner/ Child of Domestic Partner For COBRA/Cal-COBRA eligibility information for Domestic Partners and their covered dependents, please see pages 21-25.	During Initial Enrollment or Group's Annual Renewal: Coverage begins on group's effective date. Involuntary Loss of Other Coverage: Domestic Partner can be added outside of Renewal only if he/she loses other coverage involuntarily. Coverage is effective the 1st of following month. Mid-Year Addition: Mid-Year Addition: Mid-year additions of a domestic partner will require a state-stamped copy of the Declaration of Domestic Partnership from the California Secretary of State within 60 days of issuance. If domestic partners have filed a Declaration of Domestic Partnership and have not yet received a copy from the state, a signed Affidavit of Domestic Partnership will be accepted. Domestic Partners agree to provide a copy of the Declaration of Domestic Partnership within 60 days of issuance. If all required documentation is received before the 16th day of the month in which the domestic partnership was established, premiums are charged for the full month and coverage begins on the date of the event. If all required documentation is received on or after the 16th day of the month in which the domestic partnership was established, coverage begins on the 1st of the month following the date of receipt.	For a Domestic Partner to qualify, Employee and Domestic Partner must: • Both have filed a duly executed Declaration of Domestic Partnership with the Secretary of State and will provide copies to CaliforniaChoice® within 60 days of its issue. For out-of-state domestic partners, please complete the Affidavit of Domestic Partnership • Agree to notify CaliforniaChoice immediately upon termination of domestic partnership Children of Domestic Partner must also meet the dependent children requirements listed in the preceding sections. **Dependents must meet all requirements listed in order to be eligible for enrollment**

Family Coverage *(continued)*

Terminating Dependents

A covered employee's dependent may lose eligibility for coverage even if the employee's coverage continues (i.e., when a dependent child reaches the maximum age for coverage). Coverage for the dependent(s) would terminate at the end of the month of reaching maximum age. A CaliforniaChoice® **Change Request Form** should be submitted to CaliforniaChoice in each of the following situations:

- A divorce, annulment, dissolution of marriage, termination of domestic partnership or legal separation†
- A dependent child ceases to qualify as a dependent
- Death of employee
- Medicare entitlement of employee

Termination of coverage will take place at the end of the month following the event provided the group notifies CaliforniaChoice of the qualifying/triggering event within the timeframe allowed by law (within 60 days from qualifying/triggering event).

Terminating Over-Age Dependents

Coverage for dependent children automatically terminates when they reach age 26.

A notification letter will be sent to the employee 90 days before their dependents coverage terminates. The employer is not involved in this process but should be aware of its occurrence. CaliforniaChoice will advise the dependent to contact the Group Plan Administrator regarding their eligibility for benefits under COBRA continuation.

Your billing statement will be adjusted automatically according to any change in dependent coverage status for each employee.

Disabled Dependents:
Dependents who are incapable of self-support because of a continuous mental or physical disability that existed before the age limit of 26 are eligible for coverage until the incapacity ends. Documentation of disability will be requested. Once the child reaches the age limit of 26 for coverage, re-verification of disability will be required no more frequently than annually, at the child's birthday.

† If divorce or termination of domestic partnership is not final and member cancels coverage, dependent cannot be reinstated until group's next Renewal.

Special Enrollment Periods

Below is a list of the most commonly encountered qualifying/triggering events. These events trigger a Special Enrollment Period, during which an employee or dependent may make a change to their enrollment during the coverage year.

- Involuntary loss of minimum essential coverage (including, but not limited to, the following examples: loss of other employer coverage, loss of COBRA due to exhaustion, etc.)
- Marriage/Domestic Partnership
- Birth/Adoption/Legal Guardianship/Eligible Dependent Child
- Court Order
- Moving out of coverage area
- Return from active duty from Military or California National Guard
- Release from Incarceration
- Enrollment or plan change once a month due to Native American status
- Other exceptional circumstances (subject to CaliforniaChoice® approval)

Qualifying/triggering events that are not covered under Change in Family Status (see next page) will be effective first of the month following the date the request is received by CaliforniaChoice. The employee must complete and submit the necessary items to CaliforniaChoice within **60 days of the qualifying/triggering event**.

Change in Family Status

New Dependent(s) Enrollment

Employees who acquire a new dependent (i.e., newborn, new spouse, etc.) are able to change their coverage outside of the Renewal period. Even employees who previously **waived** coverage during Renewal become eligible to enroll themselves and their new dependent(s) when a qualifying/triggering change in family status occurs. Newly acquired dependents must be added **within 60 days of the qualifying/triggering event** by completing and submitting the necessary items (see chart below) to CaliforniaChoice®.

New Dependent:	Submit the Following:
Spouse	• Change Request Form • Proof of Marriage (copy of marriage certificate)*. • Date of Marriage ***If all required documentation is received before the 16 th day of the month of marriage, premiums are charged for the full month and coverage begins on the date of marriage. If all required documentation is received on or after the 16 th day of the month of marriage, coverage begins on the 1st of the month following the date of receipt.*** **** If the married parties have not yet received the state-stamped copy of the Marriage Certificate, a county issued receipt displaying the names of the parties and the date of marriage may be acceptable. Married parties agree to provide a copy of the state-stamped Marriage Certificate within 60 days of issuance.***
Registered Domestic Partner	• Change Request Form • Declaration of Domestic Partnership* • Date of Issuance of Domestic Partnership ***If all required documentation is received before the 16 th day of the month in which the domestic partnership was established, premiums are charged for the full month and coverage begins on the date of the event. If all required documentation is received on or after the 16 th day of the month in which the domestic partnership was established, coverage begins on the 1st of the month following the date of receipt.*** **** If domestic partners have filed a Declaration of Domestic Partnership and have not yet received a copy from the state, a signed Affidavit of Domestic Partnership will be accepted. Domestic Partners agree to provide a copy of the Declaration of Domestic Partnership within 60 days of issuance.***
Newborn Child	• Change Request Form • Proof of Birth (copy of birth announcement, birth certificate or hospital card) ***If birth occurred before the 16 th of the month, coverage begins on 1st day of the month of the date of their birth. If birth occurred on the 16 th or after, child is automatically covered at no cost under Subscriber between date of birth and the 1st of the following month. Coverage for the dependent begins on the 1st of the month following the birth.***
Adopted Child/ Non-Temporary Legal Ward/Eligible Dependent Child	• Change Request Form • Proof of Placement/Acceptance (legal documentation) ***If date of placement/acceptance occurred before the 16 th of the month, coverage begins on 1st day of the month of their date of placement/acceptance month. If date of placement/acceptance occurred on the 16 th or after, child is automatically covered at no cost under Subscriber between date of placement/acceptance and the 1st of the following month. Coverage for the dependent begins on the 1st of the month following the date of placement/acceptance.***
Stepchild	• Change Request Form • Proof of Marriage, or establishment of a Domestic Partnership to stepchild's parent/legal guardian (copy of marriage certificate or Declaration of Domestic Partnership)* ***If all required documentation is received before the 16 th day of the month of marriage/ establishment of domestic partnership, premiums are charged for the full month and coverage begins on the date of marriage/establishment of domestic partnership. If all required documentation is received on or after the 16 th day of the month of marriage/establishment of domestic partnership, coverage begins on the 1st of the month following the date of receipt.*** **** If domestic partners have filed a Declaration of Domestic Partnership and have not yet received a copy from the state, a signed Affidavit of Domestic Partnership will be accepted. Domestic Partners agree to provide a copy of the Declaration of Domestic Partnership within 60 days of issuance. If the married parties have not yet received the state-stamped copy of the Marriage Certificate, a county issued receipt displaying the names of the parties and the date of marriage may be acceptable. Married parties agree to provide a copy of the state-stamped Marriage Certificate within 60 days of issuance.***

Member MUST notify CaliforniaChoice of change in family status within 60 days

Change in Group Policy

Group Change Guidelines

The following charts identify various changes you may make to your group coverage policy (when permitted) and the change requirements.

Visit **calchoice.com** to download required forms.

Mail or fax completed forms to:
CaliforniaChoice®
721 South Parker, Suite 140
Orange, CA 92868
Fax: 714.558.8000
E-mail: gpc@choiceadmin.com

Change Type	When Allowed*	Deadline to Submit	Requirements To Process
Address	At any time	None	One of the following: • Employer's written notification providing new address and specifying billing and/or street address and referencing group number. Street address cannot be a P.O. Box or outside of California • Online at calchoice.com • Employer Change Request Form
Employer Sponsored Dental MetLife DHMO MET100 & MET185, SmileSaver DHMO 1000 & 3000, Ameritas PPO 3000, 3500, 4000 & 5000 (See page 30-31)	At any time once a year and at Renewal	25th of the month prior to requested effective date (if Renewal, within 30 days of anniversary date, but benefits cannot be accessed until group receives written confirmation of approval from CaliforniaChoice)	• Dental Application • Reconciled Quarterly/Annual Wage Report
Chiropractic/ Acupuncture Plan (Change)	Renewal Only	Prior to requested effective date	• Employer Change Request Form
Chiropractic/ Acupuncture Plan (Add)	At any time once a year and at Renewal	Within 30 days of requested effective date	• Employer Change Request Form
Company Name	At any time	None	• E-mail or letterhead from authorized group contact providing group number, new company name and referencing old company name
Contact Person	At any time	None	One of the following: • Employer-written request providing contact name, job title, phone, fax and e-mail and referencing group # • Online at calchoice.com • Employer Change Request Form • Group Contact Change Request
Contribution	Renewal Only	Within 30 days of Renewal	• Employer Change Request Form • Employer contribution must be a minimum of 50% of the lowest cost plan available to the employee based on employee ZIP Code

**1st of the month effective date only.*

Change in Group Policy *(continued)*

Visit **calchoice.com** to download required forms.

Mail or fax completed forms to:
CaliforniaChoice®
721 South Parker, Suite 140
Orange, CA 92868
Fax: 714.558.8000
E-mail: gpc@choiceadmin.com

Change Type	When Allowed*	Deadline to Submit	Requirements To Process
Federal Tax ID Number	At any time	None	• E-mail or letterhead from authorized group contact providing group number, new tax ID number and referencing old tax ID number
Life Insurance	At any time once a year and at Renewal	25th of the month prior to requested effective date (if Renewal, within 30 days of anniversary date, but benefits cannot be accessed until group receives written confirmation of approval from CaliforniaChoice)	• Employer Change Request Form • Reconciled Quarterly/Annual Wage Report • Employee Enrollment Applications for all eligible employees • Completed Statement of Health for all eligible employees if requesting amount above guaranteed issue amount (subject to medical underwriting)
Metal Tier(s)	Renewal Only*	A minimum of 5 business days prior to Renewal Date	• Employer Change Request Form • Employee Enrollment Applications (for non-enrolled employees only) And/Or • Employee Change Request Forms
Pay Period for Enrollment Quote	At any time once a year and at Renewal	None (change effective upon entry)	• Employer-written request
Section 125	At any time	None	One of the following: • Employer Change Request Form • Dental and/or Voluntary Vision Application(s) (requested effective date must be included)
Termination of Coverage	At any time	30 days prior to requested effective date (termination will be effective no earlier than the last day of the month following request)	• Employer-written request to include last day of coverage
Voluntary Dental	Renewal Only	25th of the month prior to requested effective date (if Renewal, within 30 days of anniversary date, but benefits cannot be accessed until group receives written confirmation of approval from CaliforniaChoice)	• Dental Application • Must enroll one or more employees
Voluntary Vision	At any time once a year and at Renewal	Within 30 days of requested effective date	• Voluntary Vision Application
Waiting Period	Renewal Only*	Within 30 days of Renewal	• Employer Change Request Form

**1st of the month effective date only.*

About COBRA

COBRA (Federal) and Cal-COBRA (State) laws allow for continuation of group health benefits to individuals who lose coverage as a result of certain "qualifying/triggering events" (e.g. termination of employment, death of employee, reduction of work hours, divorce, legal separation, Medicare entitlement, and loss of dependent child status).

The law defines "group health benefits" as medical, dental, chiropractic, vision, prescription drug programs, and any self-insured arrangements that provide similar benefit coverage. These individuals are allowed to retain the types of coverage they had prior to the event taking place and must be given the same rights as active eligible employees with respect to Renewal periods, changing plans or benefits and adding or terminating dependents.

Employers Subject to COBRA (Federal)

Generally, a company is subject to the provisions of Federal COBRA if it offers a group health plan and has 20 or more employees on at least 50 percent of its typical business days **during the preceding calendar year**.

Both full-time and part-time employees are considered as employees for purposes of this rule regardless of whether or not they are eligible for coverage under the employer's group health plan. However, under the 1999 final IRS regulations, an employer is only required to count common-law employees when determining whether they meet the 20-employee requirement. **Self-employed individuals, agents, independent contractors and corporate directors are not treated as employees for COBRA purposes and need not be counted**. Employers must aggregate employees from all divisions, subsidiaries and any other entities that make up a controlled group of corporations. In general, a controlled group of corporations may consist of a parent-subsidiary controlled group, brother-sister controlled group, or a combined group as defined under the IRS Code Section 414b.

In addition, under the 1999 final IRS rules, a part-time employee may be counted as a fraction of a full-time employee, with the fraction equal to the number of hours an employee must work in order to be considered a full-time employee, not to exceed 40 hours per week. Under these same rules, employers are also permitted to use daily or pay period methods of counting.

COBRA Basics

- COBRA is designed to extend health benefits to people who lose their coverage due to a COBRA Qualifying/Triggering Event
- Generally, a company is subject to the provisions of Federal COBRA if it offers a group health plan and has 20 or more employees on 50% of its "typical business days" during the preceding calendar year
- It is the sole responsibility of the employer to notify its employees or members of the availability, terms, and conditions of COBRA continuation

It is the sole responsibility of the employer to notify its employees or members of the availability, terms, and conditions of COBRA continuation and provide them with the necessary information/forms for COBRA election. Such responsibility will be satisfied if the former member is notified within 14 days after the last day of coverage under the Group Plan.

In the case of terminating employees/dependents and loss of dependent child status, upon proper notification, a letter from CaliforniaChoice® will be sent to the individual informing them to contact the Group Plan Administrator to verify if they are eligible for COBRA continuation.

COBRA enrollees will only be allowed to continue on their current coverage (Health Care Service Plan/Benefit Plan). Enrollees who expect to move to an area where their current Health Plan is not available should contact the CaliforniaChoice Customer Service Center at 800.558.8003.

About COBRA *(continued)*

Domestic Partner Eligibility under COBRA

Domestic Partners **do not meet** the definition of a Qualified Beneficiary as defined under COBRA law. Therefore, Domestic Partners **are not eligible** for the same COBRA rights as a Qualified Beneficiary.

The Domestic Partner **is only eligible for COBRA Continuation of Coverage if he or she remains a dependent under the employee's election**. He or she does not have a separate election right under COBRA law because he or she is not a Qualified Beneficiary. If an employee experiences a COBRA qualifying/triggering event, the Domestic Partner is only eligible to continue his or her health insurance benefits if the employee also continues his or her benefits under COBRA. He or she **cannot make an election** separate from the employee. In addition, dependent qualifying/triggering events **do not apply** to Domestic Partners.

Employer Responsibilities for COBRA

- **The employer must continue to comply with all COBRA requirements** (including proper notification of all active plan participants, notification of all qualified beneficiaries following qualifying/triggering event, etc.)
- **The employer must send a completed COBRA Enrollment Application to CaliforniaChoice® for all qualified beneficiaries who elect COBRA continuation coverage**. (The completed COBRA Enrollment Application must be returned to the employer to forward to CaliforniaChoice within the regulated time frames.)

COBRA Compliance Made Simple

The following is a brief summary of the COBRA administration services offered by WageWorks, a HealthEquity company for CaliforniaChoice groups:

1) Once CaliforniaChoice receives a COBRA Enrollment Application, WageWorks (a company contracted by CaliforniaChoice) will send a confirmation of COBRA election letter and courtesy invoice to COBRA enrollees. COBRA enrollees will be charged the current premium in effect for the employer, but with an additional 2% charge for administration.

2) For the duration of the continuation coverage, WageWorks will send a courtesy invoice to the COBRA participant for continuation coverage premiums.

3) COBRA participant payments collected by WageWorks are forwarded to CaliforniaChoice.

4) Because COBRA Enrollees must be treated the same as your active eligible employees, COBRA enrollees will be allowed to amend coverage for themselves and/or their dependents or add any additional applicable benefits offered by the former employer. (Life insurance not included.)

5) WageWorks will notify each COBRA participant of their possible conversion and extension rights near the end of their COBRA continuation coverage period.

6) WageWorks will track each participant and notify them and CaliforniaChoice of termination of their COBRA coverage.

NOTE: The services listed above do not alleviate a group's responsibilities under COBRA law. These services only apply to non-direct bill groups.

Direct Bill Groups: Groups who have elected to be billed for their COBRA participants. For additional information on Direct Bill, please contact our Customer Service Center at 800.558.8003.

About COBRA *(continued)*

Employers Subject to Cal-COBRA (State)

Generally, a company is subject to the provisions of Cal-COBRA if it offers a group health plan and only has 1 to 19 eligible employees on at least 50 percent of its typical business days **during the preceding calendar year**.

All full-time employees, part-time employees and self-employed persons (e.g. partners in a law firm) are considered employees for the purposes of this rule regardless of whether or not they are eligible for coverage under the employer's group health plan. Leased employees also count as employees. However, all agents or independent contractors (and their employees, agents and independent contractors), as well as corporate directors, are treated as employees only if they are eligible for coverage under the group health plan.

Employers must aggregate employees from all divisions, subsidiaries and any other entities that make up a controlled group of corporations. In general, a controlled group of corporations may consist of a parent-subsidiary controlled group, brother-sister controlled group, or a combined group as defined by IRS Code Section 414b.

Unlike COBRA, it is the responsibility of the Health Plans to send out notifications to former employees/dependents of their rights to continue coverage under Cal-COBRA. The Health Plans in the CaliforniaChoice® program have contracted with WageWorks, a HealthEquity company to provide those services. (See next page for information on Cal-COBRA services offered by WageWorks.)

Upon notification of a qualifying/triggering event, WageWorks will automatically notify those members of their Cal-COBRA rights by sending an election notice to the qualified beneficiaries' last known address via first class mail and give them the opportunity to elect to continue their coverage through Cal-COBRA.

Domestic Partner Eligibility under Cal-COBRA

Under the Insurance Equality Act, effective January 1, 2005, any coverage offered to the spouse of an employee must also be offered to a registered Domestic Partner.

The Domestic Partner is eligible for Cal-COBRA Continuation of Coverage and has the same election rights as a spouse.

Cal-COBRA Basics:

- Generally, a company is subject to the provisions of Cal-COBRA if it offers a group health plan and only has 1 to 19 eligible employees on at least 50% of its typical business days during the preceding calendar year
- All full-time, part-time and self-employed persons (e.g. partners in a law firm) are considered employees
- Unlike COBRA, it is the responsibility of the Health Plans to send out notifications to former members of their rights to continue coverage under Cal-COBRA

About Cal-COBRA

Employee/Dependent Responsibilities

If a covered dependent loses his or her eligibility due to divorce, legal separation, death of employee or loss of dependent child eligibility, the employee or dependent must notify CaliforniaChoice® of the event **(within 60 days)**. For divorce, legal separation, or loss of dependent eligibility the employee must submit a **Change Request Form**. Coverage will be terminated at the end of the month following the qualifying/triggering event date. The dependent must submit a COBRA Enrollment Application to elect COBRA.

Employer Responsibilities for Cal-COBRA

- The Employer must notify CaliforniaChoice of employee address changes within 30 days of the employee providing such information to the Employer.
- The Employer must notify CaliforniaChoice of employee terminations, employee deaths, and reductions in hours that cause a loss of coverage within 30 days of the event taking place by submitting an Employee Termination Notification Form.

Cal-COBRA Compliance Made Simple

The following is a brief summary of the Cal-COBRA administration services offered by WageWorks, a HealthEquity company for CaliforniaChoice groups:

1) Following notification of termination of employment, employee death, or a reduction in hours, WageWorks will send information to the member including their Cal-COBRA rights and a Cal-COBRA election form.

2) At this point WageWorks will make arrangements for the Cal-COBRA enrollees to make their payments directly to WageWorks.

3) Cal-COBRA enrollees will be charged the current premium in effect with the employer, but with an additional 10% charge for administration.

4) WageWorks will notify Cal-COBRA enrollees of their options during the annual Renewal period.

   Because Cal-COBRA enrollees must be treated the same as your active eligible employees, Cal-COBRA enrollees will be allowed to add any additional **applicable** benefits offered by the former employer as well as any eligible dependents not previously covered under Cal-COBRA (except life insurance coverage).

5) WageWorks will notify each Cal-COBRA participant of their possible conversion near the end of their Cal-COBRA continuation period.

6) WageWorks will track each Cal-COBRA participant and notify them and CaliforniaChoice of termination of their Cal-COBRA coverage.

Related COBRA Laws

Length of Eligibility for Continuation of Coverage

In September 2002, California passed a state law extending the maximum amount of time for continuation coverage under Cal-COBRA regulations.

Under Cal-COBRA regulations, anyone with a Qualifying/Triggering Event resulting in their continuation coverage period beginning on January 1, 2003 or thereafter will be eligible for 36 months of coverage. COBRA coverage beginning prior to this date is not eligible for this extension.

If the group's coverage through CaliforniaChoice® is terminated, all members, including those who have elected COBRA/Cal-COBRA continuation coverage will be terminated. The employer's obligation to the COBRA/Cal-COBRA qualified beneficiaries is to provide them with the same coverage currently provided to active employees.

A company's obligation to comply with COBRA is the same regardless of the number of employees it has during the current year.

Anyone with a Qualifying/Triggering Event resulting in their continuation coverage period beginning on January 1, 2003 may qualify for up to 36 months of coverage

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

In October of 1996, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was signed into law. In April of 1997, Federal regulations were published to assist Planholders (Employers) to comply with this law.

The major components of the law apply to medically insured members and are as follows:

- A Certificate of Coverage must be provided to all insured employees and their dependents when their coverage ends. CaliforniaChoice will automatically send this certificate upon termination and additional copies upon request.

Employers are responsible for notifying CaliforniaChoice of an employee's new address information **within 30 days** of an address change. Because of the obligations imposed by Federal and State laws, CaliforniaChoice cannot be responsible for misdirected HIPAA/COBRA/Cal-COBRA information as a result of the failure to provide correct residence address information for all insured employees.

NOTE: Life Insurance coverage may allow for disability extensions and policy conversion based on policy guidelines. The Employer is responsible for initial notification of these rights. For more information, please see a copy of the master policy at **calchoice.com** under "Download Forms, Brochures and Guides" or contact our Customer Service Center at 800.558.8003.

Billing

Your Premium Statement

Each month you will receive a Premium Statement including your policy information and total balance due, Invoice Pages breaking down employee coverage information and, if applicable, Invoice Adjustment Pages reflecting any changes, credits or adjustments made to your account.

- **POLICY INFORMATION** reflects your current metal tier, optional benefits, COBRA status, waiting period, renewal date and minimum hours for eligibility. The information provided reflects your account information as it exists on record as of the statement date.
- **The TOTAL OF CONTRACT BALANCE(S) DUE** is always the outstanding balance as of the statement date. Payments or adjustments made after that date will be reflected on your next statement.
- Your **INVOICE PAGES** will list all employees currently enrolled in the plan, including their ages and ZIP Codes, their coverage, a breakdown of their premiums and employer contributions.
- The **ADJUSTMENT PAGE** will reflect employee plan changes and terminations made since the last statement. Please pay special attention to this area to verify adjustments.
- A **COBRA Participation Cancellation Notification (Federal COBRA)** form must be completed when you become aware that a COBRA participant is voluntarily canceling COBRA coverage, canceling due to non-payment of premium or is deceased.

You should always return the remittance portion of the premium statement with your payment and indicate the group number on your check. Please do not staple/tape your check to the remittance portion. Payments can also be made online (one-time or recurring) by logging into calchoice.com.

What the Employee Change Codes Mean on Your Statement

Listed below are the employee change codes that may appear on your statements:

A	Addition
AC	Add COBRA
C	Change Plan
CA	Change Age
CE	Change Enroll Date
CI	Change Information
CO	Correction
DA	Dependent Add
DT	Dependent Termination
ER	Employee Reinstatement
GR	Group Reinstatement
IN	Involuntary Termination
NT	New Termination
PP	Partial Payment Termination
RA	Retroactive Add
RC	Retroactive Change Plan
RDA	Retroactive Dependent Addition
RDT	Retroactive Dependent Termination
RE	Resignation
RT	Retroactive Termination
VC	Life Volume Change

<P.S.>

Do not self-adjust or submit changes on your statement. Changes can only be processed using the correct forms. Please use the forms provided in your administrative kit or log on to our website at **calchoice.com**. Forms can be downloaded or printed from the site and may be emailed, faxed or mailed to CaliforniaChoice®.

Billing *(continued)*

The Billing Cycle

Your premium statements are produced by CaliforniaChoice® the 1st of each month for the following month's coverage. These statements are mailed and/or e-mailed to the Group Contact. Here is an example:

- Premium payments need to be received by the due date indicated on each statement and should be paid as billed. Adjustments processed after the statement date will reflect on your next statement.
- All payments are applied to your oldest open balance first, with any remaining portion being applied to subsequent balances.
- Payment Options include check by mail and online payments (one time and recurring).
- Cut off time for payments made online is 3:00pm (PST).

Note: Premiums are always due prior to the month of coverage.

Medical Rate Schedule

The group's medical rate schedule is guaranteed for the group's plan year. Employee/dependent rates are subject to change based on employee qualifying/triggering events listed on page 16.

Dental Rate Schedule

Dental rates will change the month following the employer's move to a different rating region.

Life Rate Schedules

Individual employee rates are subject to change based on employee age and life amount. Employee life rates are updated the month following the employee's birth month.

Medical Table	
0-14	40-40
15-15	41-41
16-16	42-42
17-17	43-43
18-18	44-44
19-19	45-45
20-20	46-46
21-21	47-47
22-22	48-48
23-23	49-49
24-24	50-50
25-25	51-51
26-26	52-52
27-27	53-53
28-28	54-54
29-29	55-55
30-30	56-56
31-31	57-57
32-32	58-58
33-33	59-59
34-34	60-60
35-35	61-61
36-36	62-62
37-37	63-63
38-38	64+
39-39	

Life Table
0-19
20-24
25-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65-69
70-74
75-79
80-84
85-89
90-94
95-99
100+

Billing *(continued)*

Credits/Fees

If there is a credit on your account due to an overpayment or adjustment, the credit will reflect on the invoice following the date of the credit. The amount due for the invoice following the credit will be reduced by the credit amount.

The administrative fee is based on the total number of employees enrolled in any coverage through CaliforniaChoice® at the time of invoicing and is, therefore, subject to change on a monthly basis. Administrative fees are as follows:

1-8 employees	$30
9-50 employees	$40
51+ employees	$50

(In addition to the monthly administrative fee, CaliforniaChoice is remunerated from the subscriber payment collected)

Returned checks must be replaced immediately with a cashier's check or money order - company checks will not be accepted. There is a $25 fee for all returned checks. If there are 3 or more returned checks within a 12-month period, payment with certified funds will be required for one year.

Group Cancellations

Should premium payment(s) not be received in full by the due date, a "Notice of Start of Grace Period" shall be sent to the group providing a 30-day grace period that begins the day the "Notice of Start of Grace" is dated and lasts at least 30 days. If premium payment(s) are not received in full by the end of the grace period, or a partial payment is received, your coverage(s) will be cancelled per the hierarchy included in the CaliforniaChoice Supplement to the Group Service Agreement (GSA). Cancellation of coverage(s) will be effective the day after the last day of the grace period*, 12:00 midnight (Pacific Time). In such a case, a "Notice of End of Coverage" will be mailed. Your coverage(s) will continue during the grace period; however, you are still responsible to pay unpaid premium(s) and any copayments, coinsurances, or deductible amounts as required under your plan contract(s) through the last day of coverage.

**Since the month of February consists of only 28/29 days, groups that do not pay February's premium by the end of the 30-day grace period will terminate on the last day of March.*

Annual Renewal Timeline

Approximately 60 days prior to the group anniversary date, CaliforniaChoice® will send the renewal premiums based on your employees' current Health Plan/Benefit selections. For example:

May 1
Renewal Begins

Employer will receive renewal package by this date

June 1
Renewal Ends

All Enrollment Forms or Change Request Forms need to be received by this date

July 1
Company Anniversary Date

Requested Changes go into effect

During Renewal, your employees will have the opportunity to change their current Health Plan/Benefit selections and add eligible dependents not previously covered on the program. Employees who previously waived are eligible to enroll at this time. Coverage will be made effective the first of the renewal month.

You may contact your CaliforniaChoice Renewal Representative for assistance with your group's renewal.

Ancillary Dental

Employee Dental Insurance

At the time your company completed initial enrollment into the CaliforniaChoice® program, you were given the opportunity to provide employee dental coverage. If you declined this coverage initially, you are allowed to add employee dental insurance at anytime throughout the year, subject to underwriting. Please contact your insurance broker for enrollment requirements.

MetLife DHMO MET100 & MET185, SmileSaver DHMO 1000 & 3000, Ameritas PPO 3000, 3500†, 4000†, & 5000†

†Only groups with 5 or more eligible employees qualify for Orthodontia benefits

Participation Requirements	
Employer	• Currently offering medical coverage through CaliforniaChoice to all eligible employees • No current dental plan being offered to any employees (by another dental carrier) • 1-2 Employees: 100% of all employees. All groups must include at least one dental enrolled employee who is not a business owner or spouse of business owner • 3-100 Employees: 70% of eligible employees enrolling in CaliforniaChoice • Employees with other group coverage are not counted towards participation unless employer contribution is 100% • The Employer must contribute a minimum of 50% of the Employee premium of the lowest cost dental plan available to employees • Employees selecting Dental 3000, 3500, 4000 or 5000 are subject to a 12-month waiting period for major services; 12 months for Orthodontia. Takeover credit is available to groups consisting of 10+ eligible employees with comparable prior group dental plan and no lapse in coverage • Employer must submit the following to receive takeover credit towards waiting period for major services and Orthodontia: ◦ Prior dental billing statement (no lapse in coverage allowed) ◦ Prior dental billing statement from 12 months prior or first statement if coverage has been in force less than 12 months ◦ Prior dental billing statement from 12 months prior for orthodontic option. Statement must show benefits for Othrodontia • Deductible takeover is not available
Employee	Eligibility is contingent upon Employer eligibility AND the following: • Expected to meet the established waiting period • Permanent and actively working an average of 30+ hours per week over the course of a month, at the small employer's regular place of business or 20+ hours per normal work week for at least 50% of the weeks in the previous calendar quarter • Paid on a salary/hourly basis (not 1099, commissioned, or substitute) • Employees hired after plan installment are subject to the waiting period
Dependent Spouse	Eligibility is contingent upon Employer eligibility AND the following: • Legally married to the Employee

Ancillary Dental *(continued)*

MetLife DHMO MET100 & MET185, SmileSaver DHMO 1000 & 3000, Ameritas PPO 3000, 3500†, 4000†, & 5000†

†Only groups of 5 or more eligible employees qualify for Orthodontia Benefits

Participation Requirements	
Dependent Children	**METLIFE and SMILESAVER** DENTAL Dependent eligibility: • Born to, a step-child or legal ward of, adopted by, on original request, or have an established parent-child relationship with the eligible employee, employee spouse or domestic partner • Under age 26 (unless disabled, disability diagnosed prior to age 26) **AMERITAS** DENTAL Dependent eligibility: • Born to, a step-child or legal ward of, adopted by, on original request or have an established parent-child relationship with the eligible employee, employee spouse or domestic partner • Financially dependent upon the employee per IRS guidelines • Unmarried or not involved in a domestic partnership • Under age 26 (unless disabled, disability diagnosed prior to age 26) Disabled Dependents: Dependents who are incapable of self-support because of continuous mental or physical disability that existed before the age limit of 26 are eligible for coverage until the incapacity ends. Documentation of disability will be requested. Once the child reaches the age limit of 26 for coverage, verification of eligibility will occur no more frequently than annually, at the child's birthday. **Dependents must meet all requirements listed in order to be eligible for enrollment**
Domestic Partner For COBRA/Cal-COBRA eligibility information for Domestic Partners and their covered dependents, please see pages 22-23	Employee and Domestic Partner must fall into all of the following categories: • Both have filed a duly executed Declaration of Domestic Partnership with the Secretary of State and will provide copies to CaliforniaChoice® within 60 days of its issue • Agree to notify CaliforniaChoice immediately upon termination of domestic partnership

Dentegra® Smile Club

This dental is a value-add available to employers who do not currently offer Employer Sponsored dental coverage to their employees.

How It Works

- New employees* can enroll in Dentegra Smile Club by first enrolling in CaliforniaChoice medical coverage. They can then visit www.calchoice.com to register/log-in, click on "Smile Club Join Now" to join the "Club". Enter ZIP Code in "Interested?" section and click "Check availability". Fill in required fields, click "Register" and then "Find a dentist" to unlock great savings. Please have employees provide the dentist with group # 17528-00001 if requested.
- When medical coverage terminates for an employee and/or dependents, coverage in Dentegra Smile Club will automatically terminate.

If your employees have issues with registration, please contact Dentegra Customer Service at 877.280.4204.

** Employees must live/reside in California.*

Ancillary and Voluntary Benefits *(continued)*

Voluntary Dental Program

CaliforniaChoice® members can enroll in one of the voluntary dental plans by Ameritas, MetLife and SmileSaver℠, with no minimum employee participation. Ameritas PPO benefits offer a low deductible that allow members to visit any dental provider they prefer, in- or out-of-network. MetLife and SmileSaver DHMO benefits are available for a low monthly premium (paid by the employee) and offer low cost or free office visits, oral exams, X-rays and two cleanings per year.

Voluntary Vision Program

CaliforniaChoice members can enroll in one of the voluntary vision plans by EyeMed and VSP, both are provided by Ameritas in addition to the automatic EyeMed Vision Discount Program. For a low monthly premium (paid by the employee), the Voluntary Vision plans allow them to save additional costs related to exams, frames, lenses and more.

How Voluntary Plans Work

- The employer must offer the coverage.
- The employee must pay for premiums.

EyeMed Vision Discount Program (provided by Ameritas)

All CaliforniaChoice medical and/or dental enrollees are automatically eligible for discounts on eye exams, lenses, frames, contacts and LASIK procedures through the EyeMed Vision Discount Program. These discounts are honored at over 2500 locations nationwide. For details, go to **calchoice.com**, select "Our Benefits" and "Vision."

How It Works:

- New employee enrollment in EyeMed is automatic upon enrollment for CaliforniaChoice medical and/or dental coverage with no monthly premium.

Our innovative mix of Optional and Voluntary benefits helps employers offer more coverage while limiting healthcare costs.

Ancillary Benefits

Chiropractic and Acupuncture Programs

CaliforniaChoice® offers each employer group a choice of two Chiropractic plans. One of those plans also includes Acupuncture services. These services are provided through Landmark Healthplan. Please see our Optional Benefits brochure for plan details. You may contact our Customer Service Center at 800.558.8003 or go online at **calchoice.com** for additional information.

How It works:

The employer must offer the coverage and pay 100% of a low monthly premium.

- The employee/dependent enrollment is automatic upon enrollment in CaliforniaChoice medical coverage (100% of all medically enrolled employees must be enrolled in Chiropractic and Chiropractic/Acupuncture.)
- When medical coverage terminates for an employee and/or dependents, this coverage will automatically terminate.

Chiropractic and Acupuncture Participation Requirements	
Employer	Must currently offer medical coverage through CaliforniaChoice Must pay 100% of Chiropractic plan premium
Employee	Must be enrolled in the CaliforniaChoice medical program and reside in California
Dependent	Must be enrolled in the CaliforniaChoice medical program and reside in California

Section 125 Premium Only Plan (POP)*

Electing this optional benefit allows the Employer to take salary deductions for certain health and insurance programs on a pre-tax basis. The Employee's insurance premium deduction (the amount the Employee pays toward medical/dental insurance for himself and/or dependents) is taken out of gross wages. By reducing the gross wage amount, this in turn reduces payroll taxes for both the Employer and the Employees.

At the time your company completed its initial enrollment into CaliforniaChoice, you were given the opportunity to elect the Section 125 program. If you did not take advantage of this benefit at that time, you may still add the Section 125 program. Please call our Customer Service Center or your insurance broker for enrollment information.

**Initial set-up fee is covered at no cost.*

<P.S.>

If your company does not currently offer these benefits and you would like more information, please contact your broker.

Ancillary Benefits *(continued)*

Employee Life Insurance

At the time your company completed initial enrollment into the CaliforniaChoice® program, you were given the opportunity to provide employee life insurance coverage.

If you declined this coverage initially, you are allowed to add employee life insurance at anytime throughout the year. Please contact your insurance broker for enrollment requirements.

Claim Filing Procedures (Loss of Life)

Claim Filing Requirements for Employers:

1) Contact our Customer Service Center at 800.558.8003
2) Complete the Life, AD&D and Waiver of Premium Claim Information form #01-878-01114
3) Complete the Employee Termination Notification Form
4) Once the above requirements are completed in full, all items should be faxed or mailed to CaliforniaChoice at the address listed below:

Attn: Life Claims
CaliforniaChoice
721 South Parker, Suite 140
Orange, CA 92868
Fax: 714.558.8000

Program Overview

At Initial Enrollment:
The minimum amount of insurance coverage per employee is $10,000

- The Employer is required to pay 100% of the life insurance premium
- ALL employees considered eligible for medical coverage must enroll in life insurance coverage—even if they waive medical and dental (a completed application is required)
- You may select to cover your employees at:

1) The same amount for all employees, (from $10,000, in increasing increments of $5,000, to the maximum amount, based on your number of eligible employees)

OR

2) A classification schedule allowing you to set up 4 amounts of coverage, with the highest amount of insurance selected no more than 2.5 times the lowest amount of insurance selected (available at initial enrollment only)

Guaranteed Issue Amounts available for both Options

Eligible Employees	Minimum	Maximum
1-10	$10,000	$25,000
11-25	$10,000	$50,000
26-50	$10,000	$75,000
51-100	$10,000	$100,000

After Initial Enrollment:
The minimum amount of insurance coverage per employee is $5,000

- The Employer is required to pay 100% of the life insurance premium
- ALL employees considered eligible for medical coverage must enroll in life insurance coverage – even if they waive medical and dental (a completed application is required)

Eligible Employees	Minimum	Maximum
1-5	$5,000	$5,000
6-10	$5,000	$10,000
11-25	$5,000	$25,000
26-100	$5,000	$50,000

- Group must go through medical underwriting if group is requesting an amount greater than the guaranteed issue amount

Life Insurance amounts are subject to the following reductions:

Reduction Schedule	
Age of Insured	**% of coverage prior to age 70**
70-74	70%
75+	40%

Frequently Asked Questions

General Information

Who is CaliforniaChoice®?

CaliforniaChoice is the TPA (Third Party Administrator) that has brought several insurance companies together to allow you and your employees the ability to select different plans of health coverage.

Who is the Group Plan Administrator?

The Group Plan Administrator is the employee selected by your company to be the main contact to CaliforniaChoice.

Who is my Health Plan?

Your Health Plan is the participating insurance company you selected under the CaliforniaChoice program to provide your health care. Each one of your employees made his or her selection during initial enrollment (i.e., Anthem Blue Cross, Cigna + Oscar, Health Net, Kaiser Permanente, Sharp Health Plan, Sutter Health Plus, UnitedHealthcare, Western Health Advantage).

Can a member change their health plan or benefit plan?

Yes, during the annual renewal period or when the employee moves to an area where there are no medical providers under the current health plan. (It is important to notify CaliforniaChoice of an address change immediately.)

If the employee experienced a qualifying/triggering event (see page 16 for a list of qualifying/triggering events), CaliforniaChoice will allow the employee to change his or her health plan/benefit plan outside of their renewal period. See page 17 for further details.

Can each family member select a different health plan?

No, all family members must select the same health plan, however each member may choose a different Primary Care Physician (PCP).

What is my benefit plan?

The level of coverage/benefits is on your enrollment application (i.e., HMO, EPO, and PPO plans).

Can each family member select a different benefit plan?

No, all family members must select the same benefit plan.

When can dependents obtain coverage?

Eligible dependents may be added at the employee's initial enrollment, when acquired (newborn/adoption/marriage/domestic partnership), or during the annual renewal period. Other than during the annual renewal period*, dependents may only be added when first eligible (i.e., newborns and newly acquired dependents may be enrolled within 60 days of the qualifying/triggering event: date of birth, adoption, marriage, domestic partnership). Please refer to "New Dependent(s) Enrollment" on page 17 for instructions.

What is an Orientation Period?

Employers offering group coverage may choose to impose an Orientation Period that is not longer than "one month" as defined in **45 CFR 147**. Use of Orientation Periods are at each employer's discretion; however, they should not be executed in an attempt to delay health enrollment. Employers should be able to support that their Orientation Periods are for legitimate business purposes such as orientation certification or training.

Does the Orientation Period Count Against the Waiting Period?

No, the Waiting Period starts the day after the Orientation Period ends.

When is my company's annual renewal?

Your company's annual renewal period begins no later than 60 days in advance of your anniversary date (your company's initial effective date). All changes made during the annual renewal are effective on the company's anniversary date. Check with the Group Plan Administrator for the exact date.

What payment options do I have?

You can mail in a check or login to your account at calchoice.com to make a one-time online payment or set-up recurring payments.

**See "Late Enrollee" on page 9 for further information.*

Frequently Asked Questions *(continued)*

HMO

What is a copayment?

The amount the member must pay for medical services (doctor visits, drug prescriptions, hospitalizations, etc.).

Who/What is my Primary Care Physician?

A Primary Care Physician can be a family practitioner, internist, or pediatrician. At the time of enrollment, you may have selected (or been assigned) a Primary Care Physician for yourself and each dependent. The Primary Care Physician coordinates all health care and medical needs including basic care, preventive services, referrals to specialists, and hospitalization arrangements.

Can each family member select a different Primary Care Physician?

Yes, each family member may choose a different Primary Care Physician who is best suited to his or her needs (i.e., the employee and spouse may want to select a general practitioner, while selecting a pediatrician for their dependent children).

Can I change my Primary Care Physician?

Yes; contact your Health Plan's Member Services Department using the phone number on your medical ID card. Plans may allow you to change your PCP through their website (some restrictions may apply).

What if I need to see a specialist?

Under the HMO plans, your Primary Care Physician, in consultation with a contracted Medical Group or IPA, will determine the proper treatment and make referrals to specialists when necessary. A change in Primary Care Physician or Health Plan could cause a problem if you are in the middle of specialist treatment.

What if medical services are needed before medical ID cards are received?

The member should present his or her welcome letter, which highlights benefit coverage; to the Primary Care Physician selected for services. The physician's office may then contact CaliforniaChoice to assist with verifying coverage.

What if a prescription is needed before medical ID cards are received?

The member should make sure the pharmacy he or she wishes to use works with their Health Plan. The member will need to pay the full amount of the prescription up-front, but may request reimbursement by retaining the paid receipt and contacting the Health Plan's Member Services Department.

What if I have an emergency situation?

In the event of any emergency, contact 911*. If it is not a life-threatening emergency, contact your Primary Care Physician first. Depending on the nature of the emergency, your physician will either: help over the phone; make an appointment for you to come in as soon as possible; or make a referral to an emergency room or urgent care facility.

* If the emergency is life threatening, you (or a family member) must contact your Primary Care Physician within 24 hours. If you are unable to get in touch with your Primary Care Physician, contact the Health Plan's Member Services Department on your ID card.

If hospitalization is necessary, which hospital will I use?

Primary Care Physicians work with specific hospitals; check your ID card, the provider directory, or ask your Primary Care Physician. In an emergency situation, always go to the nearest available hospital.

What if I need to see a doctor while away from home?

If you are away from home and cannot see your Primary Care Physician, you will only be covered for emergency treatment that is medically necessary. Contact your Primary Care Physician first to obtain authorization. If you are unable to get in touch with your Primary Care Physician, contact the Health Plan's Member Services Department on your ID card.

What if I receive a bill directly from the Facility?

Although you should not receive bills for medical care provided or approved by your Primary Care Physician, you may receive a bill in error. In that event, contact your Health Plan's Member Services Department for assistance.

Frequently Asked Questions *(continued)*

PPO Plans

What if a prescription is needed before medical ID cards are received?

The member should make sure the pharmacy he or she wishes to use is contracted with the selected health plan. Some plans require a deductible be met prior to prescription copays. The member will need to pay the full amount of the prescription up-front, but may request reimbursement by retaining the paid receipt and calling the Health Plan's Member Services Department after a medical ID card has been received.

If hospitalization is necessary, what hospital will I use?

The accredited hospital you choose to use is up to you, but remember that medical services will be covered at a greater percentage at those hospitals listed in your provider network. Check with your Health Plan's Member Services Department if you are unsure if the hospital you are considering is a provider in the network for your Health Plan. In an emergency situation, always go to the nearest available hospital.

Dentegra® Smile Club

What is Dentegra Smile Club?

Dentegra Smile Club is not insurance; it is a no-cost membership wellness program that allows members to receive negotiated discounted rates from Dentegra network dentists. Because it is not a dental insurance product, members are responsible for all payments to providers for any services rendered. Membership is available only in California and Texas.

I'm not enrolled in the medical program. Can I (or my dependents) join Dentegra Smile Club?

No, only those persons who are enrolled in the medical program qualify for Dentegra Smile Club membership.

Can each family member go to a different dental office?

Yes. Family members may visit the dental office of their choice, however, the facility and dentist must be a Dentegra Smile Club provider.

Who should I call with questions about coverage?

Members can call Dentegra customer service at 877.280.4204 or visit dentegrasmileclub.com if they:

- Need to replace a lost ID card(s)
- Have questions about how to use the plan
- Need to obtain a list of dental offices in their area.
- Please provide the dentist with group # 17528-00001, if requested.

Frequently Asked Questions *(continued)*

MetLife DHMO MET100, MET185 or SmileSaver DHMO 1000, 3000

What is my dental plan design?

MetLife DHMO MET100 or MET185 or SmileSaver DHMO 1000 or 3000.

May I or my dependents obtain MetLife or SmileSaver DHMO coverage, but not be enrolled in the medical program?

Yes.

Can each family member go to a different dental office?

Yes, each family member can go to a different dental office/dentist. If you and/or your dependents would like to switch dental offices/dentists, contact Customer Service Department at 800.880.1800.

What if I receive a bill?

Although you should not receive bills for dental care provided or approved by your dental office, you may receive a bill in error. Contact the Customer Service Department at 800.880.1800 for assistance.

Ameritas PPO 3000, 3500, 4000, & 5000

May I or my dependents obtain Ameritas PPO coverage but not be enrolled in the medical program?

Yes.

Can each family member go to a different dental office?

Yes, each family member can go to a different dental office/dentist.

What if I need to see a dentist while away from home?

You are not restricted to see any specific dentist. However, the benefits will be covered at a lower amount for major services provided by a non-contracting dentist.

What if I receive a bill?

If you take your claim form with you to your dental visit, the dentist will generally complete all of the paperwork and send you a bill only for the amount you are responsible to pay.

Supply Request Form

Forms can also be downloaded at **calchoice.com** after your employer login.

Date: _____ Group #: _____

Mail Supplies To:

Attn: _____

Company Name: _____

Address: _____

Phone #: _____

Supplies Requested

Quantity		Quantity	
_____	Employer Change Request Form	_____	Change Request Form
_____	Employee Enrollment Packet	_____	Death Claim Packet
_____	New Hire Enrollment Quote Request Form	_____	Misc. _____
_____	COBRA/Cal-COBRA Enrollment Form		_____
_____	Affidavit of Domestic Partnership		_____

Mail or Fax Supply Request Form to:

CaliforniaChoice® Supply Request
721 South Parker, Suite 140, Orange, California 92868
FAX 714.953.4097

Please be advised that some forms and written communications are available on our website in the following languages: Chinese, Korean, Russian, Spanish, Tagalog, and Vietnamese. Employees can register their applicable, Plan-specific preferred language by completing the Language Assistance Preference Form also found on our website (calchoice.com).

This Form May be Photocopied and Used as Necessary

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