Effective October 1, 2019

Application Eligibility and Underwriting Process Guide

For Individual and Family Off-Exchange Plans and Medicare Supplement plans

What you'll find inside

- Application processing information
- Eligibility
- Special enrollment periods
- Underwriting tips
- Broker resources

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Speed dial
For fast answers to application/underwriting questions, contact:

Producer Services
(800) 559-5905
ProducerServices@
blueshieldca.com

Introduction

We are pleased to present the latest edition of the Blue Shield *Application Eligibility and Underwriting Process Guide* – one of the many tools we regularly provide in an effort to make it easier for you to sell Blue Shield of California and Blue Shield of California Life & Health Insurance Company (Blue Shield Life) products.

This edition of the guide continues to focus on changes effective October 1, 2019, as required by the Affordable Care Act (healthcare reform), signed into law March 23, 2010. It also includes enrollment information for grandfathered plans and information about special enrollment periods. **Important note:** This guide focuses on off-exchange enrollment only; for information concerning on-exchange enrollment rules, please refer to CoveredCA.com.

Your clients may be eligible for tax credits to help pay their monthly premiums, or even to enroll in a plan with lower cost-sharing for medical services. To take advantage of these subsidies, consumers who qualify must enroll through Covered California (CoveredCA.com). We can guide you through the qualification process to help you determine if your clients are eligible for subsidies, and whether it makes sense for them to apply for a Blue Shield plan through Covered California or directly through Blue Shield.

Blue Shield's enrollment process philosophy

The guidelines detailed here represent our application processing procedures and general approach to enrollment for new (non-grandfathered) business and existing (grandfathered) business.

Enrollment decisions for new plans are based on eligibility underwriting guidelines, which consist of the applicant's residency, limiting age (for certain plans),* and any qualifying events (also known as a "life event change"). Depending on the information provided on the application, as well as any additional information acquired during the enrollment period, the underwriter might request and consider additional documentation to validate eligibility (to establish California residency in the plan's service area, limiting age, and any qualifying events) for a Blue Shield plan. Information related to medical or health history, lifestyle, or behavioral preferences are not requested or used to determine eligibility for enrollment in a new Blue Shield IFP medical plan.

* Age limits are associated with pediatric dental and vision benefits (up to age 19); enrollment in a Medicare Supplement plan; and for dependent status (up to age 26 if enrolling as a child dependent in an IFP plan).

Only Blue Shield can make the final decision to accept or decline an application, or to determine the effective date of coverage. Brokers are **not** authorized to bind or guarantee coverage, or establish a specific rate or effective date. Please advise all prospective members to maintain their current coverage until Blue Shield notifies them in writing of our decision regarding their application for coverage.

Blue Shield will not refuse to enter into any contract, cancel, or decline to renew or reinstate any contract because of the race, color, national origin, ancestry, religion, sex, genetic history, marital status, sexual orientation, or age of any individual applicant or member. Blue Shield also will not modify the benefits or coverage of any contract because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or age, except for premium, price, or charge differentials because of the age of any individual when based on objective, valid, and up-to-date statistical and actuarial data.

This booklet provides a general description of Blue Shield's individual eligibility and enrollment process for grandfathered plan requests to add dependents to coverage. Other criteria and guidelines not contained in this booklet may apply.

The guidelines provided in this booklet are the proprietary business information of Blue Shield. No part of this document may be copied, reproduced, or redistributed in any form or by any means without the express prior written permission of a Blue Shield officer or a Blue Shield sales director. If you have any questions, contact Producer Services at **(800) 559-5905**.

Updates

In general, the information provided in this *Application Eligibility and Underwriting Process Guide* booklet is updated and published annually. We make every effort to keep you updated on any interim changes to this information; however, policies and/or procedures may change without advance written notice.

Thank you for your support in making Blue Shield a popular choice among Californians.

Application process

The basics

Our internal tracking system monitors applications at each stage of the enrollment process when applying directly with Blue Shield – from receipt to determination. We notify you and your client in writing when a final determination is made on the application. In most cases, you and your client should receive notice of our final determination within 10 days of submission of a **complete** application.

Delays may occur when we need to request additional information from the applicant, such as verification of documented California residency, limiting age validation, proof that a qualifying event has occurred, or initial dues/premium payment. In such cases, we can't estimate the length of time necessary to complete the application process as it depends on several factors, including how long it takes for us to receive the requested information.

Important reminder: A complete IFP application requires the submission of the initial dues/premium payment.

Important for replacement of other coverage: If your clients are replacing other health plan coverage, please advise them not to cancel their existing coverage until they receive written notification that they have been accepted for Blue Shield coverage.

Payment options

Blue Shield requires payment of the first month's dues/premium with all application submissions for Individual and Family Plans (IFP). If the first month's dues/premium is not included with the IFP application, the application will be delayed, or even returned. Payment will be processed only if the application is approved. If payment is received via check, and the application is not approved by Blue Shield, the check will be destroyed.
Note: Acceptance of payment by Blue Shield does not constitute an approval, or a declaration, of coverage.

Once coverage is approved, we offer three convenient payment options:

1. Automatic payment

This option lets your clients have their IFP or Medicare Supplement plan dues/premiums automatically deducted from their checking or savings account.

Simply have your clients go online through the member portal to complete and submit their payment option. They may make a one-time or reoccurring payment at **blueshieldca.com**.

Medicare Supplement plan members who choose automatic payment by EFT draft will save $3 per month on their Medicare Supplement plan dues.* This savings program does not apply to IFP plans.

Clients can also make a payment over the phone using their bank account by calling Customer Service at **(888) 256-3650**.

2. Online payment

IFP members can choose to make a one-time payment or set up recurring payments from a bank account online. They can even view their billing statements and payment history online.

To use this tool, they need to register as a member at **blueshieldca.com**. Once registered and logged in, they will click on *Payment Center*, then *Pay My Bill*.

3. Paper billing

IFP or Medicare Supplement plan members who prefer to receive and pay their bill by mail can choose our paper billing option. The payment due date will be included on each bill they receive. IFP members and Medicare Supplement plan members on paper billing will be set up for monthly billing.

All payments should be sent to:

Blue Shield of California
P.O. Box 54530
Los Angeles, CA 90054-0530

* Medicare Supplement plan members must agree to paperless statements to receive $3 savings per month if paying by EFT draft. Savings due to increased efficiencies from administering Medicare Supplement plans under this program/service are passed on to the subscriber.

Cancellation and reinstatement

Cancellation – general provisions

Blue Shield coverage under the *Evidence of Coverage and Health Service Agreement* (Agreement) or Policy is guaranteed renewable by the individual subscriber, except as specifically set forth in the Agreement/Policy and as allowed by law. The following is only an overview; the information contained in the Agreement/Policy governs, so please refer to the Agreement/Policy for complete information.

Members who want to terminate the Agreement/Policy shall give Blue Shield 30 days' written notice.

Blue Shield may terminate the Agreement/Policy, together with all like Agreements/Policies, by giving 90 days' written notice.

Blue Shield may cancel an Agreement/Policy immediately upon written notice for the following reasons:

1. Member has moved and established permanent residence outside of California.
   Note: Medicare Supplement members moving out of California have the option to remain on their current Medicare Supplemental plan by request, but their rates will be adjusted to those applicable for Region 1. However, dental or dental/vision plans are not portable and must be cancelled.
2. Fraud or deception in obtaining, or attempting to obtain, benefits under the Agreement/Policy.
3. Knowingly permitting fraud or deception by another person in connection with the Agreement/Policy, such as, without limitation, permitting someone else to seek benefits under the Agreement/Policy, or improperly seeking payment from Blue Shield for benefits provided.

Cancellation of the Agreement/Policy will terminate the Agreement/Policy effective as of the date that written notice of termination is mailed to the subscriber. It is not retroactive to the original effective date of the Agreement/Policy.

Cancellation for nonpayment of dues/premiums

Blue Shield requires pre-payment for the coverage period for Individual and Family Plans. If dues/premiums have not been received by the due date, Blue Shield will send a Prospective Notice of Cancellation/Notice of Intent to Cancel that states:

a. Dues/premiums have not been paid, and that the Agreement/Policy will be cancelled if the required dues/premiums are not paid by the end of the grace period;

b. The specific date coverage will end if dues/premiums are not paid; and

c. Information regarding the consequences of any failure to pay the dues/premiums.

Within five business days of canceling or not renewing the Agreement/Policy, Blue Shield will mail a Notice Confirming Termination of Coverage, which will inform the subscriber of the following:

a. That the Agreement/Policy has been cancelled, and the reasons for cancellation;

b. The specific date coverage ended; and

c. **If applicable**, information regarding the availability of any reinstatement of coverage under the Agreement/Policy.

Grace period for payment of dues/premiums

After payment of dues/premiums for the first period of coverage, the subscriber receives a 30-day grace period for payment of dues/premiums for subsequent periods of coverage. During the grace period, coverage remains in force; however, the subscriber is responsible for payment of all dues/premiums that accrue while coverage is in effect (including the period of coverage provided during the grace period). If dues/premiums are not paid by the end of the 30-day grace period, coverage is cancelled effective at the end of the grace period.

Rescission

Blue Shield may, in accordance with state and federal law, be entitled to rescind coverage if the member or anyone acting on his or her behalf commits fraud or makes an intentional misrepresentation of material fact in the application for coverage or in other communications with Blue Shield prior to the issuance of the coverage. Rescission voids the coverage as if it never existed and, therefore, will be retroactive to the original effective date of coverage.

If Blue Shield rescinds coverage due to fraud or intentional misrepresentation of a material fact made by an applicant during the enrollment process, Blue Shield will take back the commissions paid to a broker.

Blue Shield expects that applicants will be provided a copy of the full application to carefully review. If you are assisting an applicant in completing the application, Blue Shield requires that the applicant review each question as it appears on the application. Do not skip questions, summarize them, or paraphrase them in any way.

In addition to English, Blue Shield offers its applications in several threshold languages: Spanish, Chinese, Korean, and Vietnamese. Please make certain that your clients are provided with an application written in their preferred language.

Never have your clients sign a blank application. They may only sign the application after it has been fully completed and they have carefully reviewed the answers.

Finally, please carefully review and complete the questions in the "Producer Information" section of the IFP or Medicare Supplement plan application. Discrepancies and/or incomplete information will delay the processing of your client's application.

Utilization review process

State law requires that health plans disclose to plan members and providers the process used to authorize or deny healthcare services under the plan. Blue Shield has documented this process ("Utilization Review"). Please call the appropriate customer service department toll-free at the number listed below to request a copy of this document:

Blue Shield IFP plans	**(888) 256-3650**
Blue Shield Medicare Supplement plans	**(800) 248-2341**

IFP applications

Eligibility

Conditions of eligibility

To be eligible for a Blue Shield Individual and Family Plan, your client must be a resident of California and reside in the Blue Shield service area for that plan.

Dependent coverage is available for:

- Spouses
- Domestic partners
- Dependent children who are younger than age 26

Grandfathered IFP health plans

Grandfathered health plans are those plans that were in effect on or before the date the ACA was signed into law (March 23, 2010). Grandfathered plans do not need to comply with all reform provisions, like guaranteed issue and designated enrollment periods; however, grandfathered plans are still required to comply with some of the health reform requirements (e.g., the elimination of the lifetime benefit maximum, and additional benefits for preventive services).

Additional coverage considerations

The Affordable Care Act permits enrollment in a new Blue Shield health plan (non-grandfathered plan) during the annual open enrollment period. Unless there is a qualifying event, an applicant who does not enroll during the annual open enrollment time frame will not be eligible for coverage until the next open enrollment period.

During the open enrollment period, Blue Shield will not require, request, or obtain medical history information from applicants for eligibility underwriting purposes. To be eligible for one of Blue Shield's medical plans, an applicant must be a valid California resident or a legitimate dependent of the applicant and reside in a ZIP code area or region that offers coverage.

Enrollment in a health plan outside of an open enrollment period will be permitted only during a special enrollment period due to a qualifying event, such as the birth of a baby, marriage, etc. Qualifying events will be discussed in more detail later in this guide. For additional information concerning eligibility, please contact your Blue Shield IFP Sales Specialist or Producer Services at **(800) 559-5905**.

Qualifying event period/special enrollment period

A qualifying event is also known as a "life event change" and is considered a personal modification or change in status. A qualifying event generally allows enrollment in the health plan during a special enrollment period (SEP), which can occur year-round, even during an open enrollment period. Under the ACA, there are specific qualifying event scenarios that allow enrollment outside of the annual open enrollment period. Special enrollment periods are discussed in detail later in this guide.

Adding dependents

Non-grandfathered Individual and Family Plans

Adding a dependent child, spouse, or partner to an existing plan is allowed only during an open enrollment period. Open enrollment periods occur annually. The exception to this requirement may be due to a qualifying event, which is discussed later in this guide under "IFP Special Enrollment Period."

Grandfathered Individual and Family Plans

If your clients want to add recently eligible dependents to their existing grandfathered coverage (newborn/recently adopted children, new spouses, etc.), they should:

1. Fill out the IFP application (Form C12900-RD)
2. Mark the box, "Add family member to existing coverage"
3. Submit it to the Consumer Eligibility Compliance Department

Members in grandfathered plans may add a dependent child to their contract without underwriting if Blue Shield receives the request to add the dependent within 31 days of birth, or for a dependent child placed for adoption within 31 days of the date on which the adoptive child's birth parent or other appropriate legal authority signs a written document – including, but

not limited to, a health facility minor release report, a medical authorization form, or a relinquishment form granting the subscriber, spouse, or domestic partner the right to control the health care for the adoptive child. An enrollment request must accompany one of these forms to process the request appropriately. Coverage will be effective the date of birth, or in the case of adoption, the date on which the right to control the health care of the adoptive child is awarded. Absent written documentation regarding the right to control the health care of an adoptive child, coverage will become effective on the date there exists evidence of the subscriber's, spouse's, or domestic partner's right to control the health care of the child placed for adoption.

Tell your clients their rates may be adjusted to reflect the changes made to their plan contract or policy. If higher monthly dues/premiums are assessed, Blue Shield will bill your clients for the difference or deduct it from their bank account (if your client has elected our automatic payment option).

Deleting dependents

Requests to cancel dependents from a family plan or from an application that is in process may be made by calling Producer Services at **(800) 559-5905**.

Bundling/unbundling policy

Changes to the contract or policy, including bundling or unbundling dependents, may be made only during the annual open enrollment period. An exception may be made following a qualifying event. Please refer to the "IFP Special Enrollment Period" section of this guide for information regarding contract or policy changes outside of open enrollment.

If a dependent currently covered under a separate grandfathered plan wants to be bundled under the parent's current Blue Shield grandfathered plan, a completed Application for Blue Shield Individual and Family Health Plans for Grandfathered Plans Only (Form C12900-RD) must be submitted for review.

Exception: Family members, each of whom has coverage under the same grandfathered plan and tier, may be bundled with the same grandfathered plan and tier without review. These requests can be made by phone or mail (see the "Key Contacts and Resources" section in the back of this booklet).

IFP special enrollment period

Generally, new enrollment and changes to the IFP contract or policy can only be made during open enrollment, which occurs on an annual basis. This is true for Blue Shield plans sold through Covered California, as well as Blue Shield plans purchased directly through Blue Shield. The open enrollment period allows eligible applicants to enroll in a health plan.

Special enrollment periods allowing individuals to apply for or change coverage outside of the annual open enrollment period due to a qualifying event only apply to new ACA-compliant plans effective January 1, 2014. A qualifying event is a life change resulting in the need to obtain health coverage.

The special enrollment period, due to a qualifying event, may apply to the entire family or only to the person affected. For example, a family with a newborn infant may enroll the child as an individual effective the child's date of birth, OR, the family may be enrolled effective the child's date of birth. A qualifying event affects the coverage needs of the family, as well as the individual affected. Special enrollment rules do not apply to grandfathered plans. Refer to the current Qualifying Events Checklist for details on all qualifying events triggering a special enrollment period.

Requirements pertaining to special enrollment periods and qualifying events

To qualify for enrollment due to a qualifying event, the applicant must submit the application for consideration usually within 60 days after the qualifying event (known also as a triggering event). For loss of minimum essential coverage, an application may be submitted up to 60 days prior to the triggering event in order to avoid a lapse in coverage. Specific eligibility documentation will be required.

Additional information concerning special enrollment periods and required documentation in support of the qualifying event may be obtained by contacting Blue Shield Producer Services at **(800) 559-5905**.

IFP effective dates during open enrollment and special enrollment periods

Blue Shield IFP plan effective dates are dependent on several factors including the date we receive the application and the type of coverage being requested. Please refer to effective date rules below.

IFP open enrollment period

Applications with premium payment received between the 1st and the 15th of the month will be effective on the 1st of the next month. Applications with premium payment received between the 16th and the 31st of the month will be effective on the 1st of the month following the next month. For example, an application received December 5 will have an effective date of January 1, and an application received December 17 will have an effective date of February 1.

The bill date for new clients is the first of the month, so if your client is approved for an effective date other than the first of the month, the bill for the first month will be prorated.

IFP special enrollment period

The effective date assigned is based on the type of qualifying event. In most instances, the effective date is the 1st of the month following receipt of an application with notification that a qualifying event has occurred. For example, an applicant has gotten married and wishes to enroll both him/herself and his/her spouse. The request for coverage (application) is received February 20, and therefore coverage is effective March 1.

Please be aware that the effective date differs based on the type of qualifying event. A special enrollment period can apply to both new and existing contracts. The special enrollment period is usually limited to **60 days** from the date of the qualifying event. Note, the first month's premium payment must be received by Blue Shield prior to activation of coverage.

Transfer guidelines

- Plan transfers are permitted during open enrollment or during a special enrollment period.
- Members can transfer to any marketed (open) health plan.
- There is no age restriction for transfers. Members of all ages (including those age 65 and older) are eligible.
- A set of eligibility criteria must be met in order for a member to transfer during a special enrollment period.
- Grandfathered plans – transfer considerations:
  - Grandfathered members in non-marketed (closed) plans will not be allowed to transfer back to their original plan once they have transferred out of the non-marketed plan to the plan requested.
  - In addition, they will lose their grandfathered status if they choose to transfer plans.

IFP applications

Final determination client conversations

When your clients and their dependents receive a final eligibility determination from Blue Shield, you may need to communicate some or all of the following information depending on the circumstances.

Denied coverage

On family applications, if any of the applicant's family members are not eligible for Blue Shield coverage, the applicable portion of the initial payment will be applied toward future monthly dues/premiums for the approved member(s) on the application. If your client prefers to receive a refund of these dues/premiums, he or she must request it by calling Blue Shield Customer Service at **(888) 256-3650**.

Right-to-return policy

If your clients find that they're not satisfied with their contract, they may return it to:

Blue Shield of California
P.O. Box 272560
Chico, CA 95927-2560

If your client sends the contract back to us within 10 days of receiving it, we will treat the contract as if it had never been issued and return all of your client's payments.

Appeal of an eligibility decision

Your clients can appeal an eligibility decision by sending a written request to the Applicant Appeals and Grievance Department. The request needs to include information pertinent to the appeal. Mail or fax the request to Blue Shield at:

Blue Shield of California
Attention: Applicant Appeals
P.O. Box 5588
El Dorado Hills, CA 95762-0011

Fax: (844) 696-6071

Your clients may write to us directly. Or they can provide you with the information to submit to us on their behalf.

If your clients have questions about appealing an underwriting decision, they may call us at **(888) 256-3650**.

Medicare Supplement plan applications

Eligibility

Clients may apply to enroll in any of Blue Shield's Medicare Supplement plans if they are:

- Age 65 or older
- A resident of California
- Enrolled in Medicare Parts A and B, Title 18, Public Law 89-97, at the time of application

Enrollment in Blue Shield's Household Savings Program is available to members age 65 and over for all Medicare Supplement plans and may result in additional monthly savings* when the following conditions are met:

- Both participants must reside at the same address.
- Both participants must have matching enrollment in all products (medical, dental, or dental/vision).
- Neither participant is a tobacco user.

Welcome to Medicare Rate Savings

New members in Medicare Supplement plans A, F Extra, and G, that are age 65 or older, receive a $25 savings* each month for their first 12 months of coverage when we receive their application within six months of the date they first enrolled for benefits under Medicare Part B.

Medicare Supplement dental or dental + vision plans

New members that enroll in a Medicare Supplement plan and one of the Medicare Supplement dental or dental + vision plans at the same time may qualify to save $3 per month for six months.

Clients who are age 64 or younger may be able to enroll in a Blue Shield Medicare Supplement plan under the following conditions:

- They are residents of California.
- They are enrolled in Medicare Parts A and B, Title 18, Public Law 89-97, at the time of application.
- They qualify for guaranteed acceptance in a Blue Shield Medicare Supplement plan according to Blue Shield's guidelines.
- They have not been diagnosed with end-stage renal disease.

If your client qualifies for guaranteed acceptance, completion of the Health Statement is neither required nor requested.

Guaranteed acceptance (GA) plans

To qualify for guaranteed acceptance, your client must meet specific criteria as outlined in Blue Shield's *Guaranteed Acceptance Guide*. For additional information about qualifying for guaranteed acceptance in a Blue Shield Medicare Supplement plan, please refer to the *Guaranteed Acceptance Guide* (Form MSP17149). You'll find a copy at Producer Connection on **blueshieldca.com/producer**. Or contact Producer Services at **(800) 559-5905**.

Rate guarantee policy

Medicare Supplement plan rates may change from time to time in response to the rising cost of health care. However, new members are given a six-month rate guarantee to shield them from these changes for at least six months. Please note, any changes requested by the member to their coverage will affect their eligibility for a rate guarantee.

Effective date of coverage

Medicare Supplement plans are effective the 1st of the month. However, the effective date can't be earlier than the date the client becomes entitled to Medicare Part B.

For those who enrolled in Medicare Part B within three months prior to submitting an application for one of our Medicare Supplement plans, we will coordinate the effective date of their Medicare Supplement plan with the effective date of their Medicare Part B unless a later effective date is requested. Example:

* Savings are due to increased efficiencies from administering Medicare Supplement plans under this program, and are passed on to the subscriber. "Welcome to Medicare Rate Savings" do not apply to Plan N.

A Medicare Supplement plan applicant enrolled in Medicare Part B effective February 1. The application is submitted January 27, and approved February 6. This applicant will be given a February 1 effective date, unless a later date is requested.

For those who have been enrolled in Medicare Part B for more than three months prior to submitting an application for one of our Medicare Supplement plans, the effective date of coverage will be the 1st of the month following the date the application is approved by Underwriting, unless a later effective date is requested. Example: A Medicare Supplement plan application approved on May 16 will have a June 1 effective date, unless a later date is requested.

Exceptions:

- Medicare Supplement plan applicants can choose a different effective date if they prefer, which helps with coordination of any current health coverage expiration. However, the requested effective date must follow the receipt date of the application and cannot be later than 90 days after the applicant's signature date on the application.
- All effective dates will be later than the application receipt date, except for applicants eligible under guaranteed acceptance scenario one.

The bill date is always the first day of the month.

Switching from another plan to a Blue Shield Medicare Supplement plan

Applicants should never disenroll from current coverage until coverage with Blue Shield has been approved.

If your client has a Medicare Advantage Plan or Medicare Advantage Prescription Drug Plan

The law prohibits Medicare Supplement plans from enrolling anyone who is currently enrolled in a Medicare Advantage Plan, unless the effective date of coverage is after the termination date of the individual's coverage under Medicare Advantage.

For clients who are members of a Medicare Advantage Plan and would like to enroll in a Medicare Prescription Drug Plan and/or a Blue Shield Medicare Supplement plan, it is in their best interest to choose one of the options listed below to disenroll from the Medicare Advantage Plan. This will help ensure that the current Medicare Advantage coverage is terminated, and the client's Original Medicare coverage – which works in conjunction with Medicare Supplement coverage – is in place. For that reason, we will work with your clients to coordinate the effective date of any Medicare Supplement coverage we approve with the date they disenroll from their current Medicare Advantage Plan.

Options for disenrollment in Medicare Advantage

If your client also plans to enroll in a Medicare Prescription Drug Plan (PDP), make sure they enroll in a Medicare PDP *before* disenrolling from their Medicare Advantage Plan. During the Annual Election Period, disenrolling from a Medicare Advantage Plan will count as their election, and your client may have to wait until the next annual election period to be able to enroll in a Medicare PDP. Enrolling in a Medicare PDP will automatically disenroll your client from their Medicare Advantage Plan.

If your client is only interested in applying for a Medicare Supplement plan without a Medicare PDP, they may choose one of the options below to disenroll from their Medicare Advantage Plan.

Option 1

Your client can go directly to their Social Security office and disenroll there. If your client chooses this option, please advise them to get a copy of the disenrollment form, including the date stamp from the Social Security office, for their records. Please fax or mail a copy of the form with the Social Security date stamp to Blue Shield.

Option 2

Your client can call the Centers for Medicare & Medicaid Services (CMS, the federal agency that administers Medicare) at (800) MEDICARE and ask to be disenrolled from their current Medicare Advantage Plan. CMS will either mail or fax your client a confirmation of termination from the Medicare Advantage Plan. Please mail or fax a copy of the termination confirmation to Blue Shield (see below).

Option 3

Your client can make a request to his or her current Medicare Advantage Plan to be disenrolled. This request can be made in one of two ways:

- By calling their current Medicare Advantage Plan and asking for a disenrollment form to be sent to them – then completing and returning the form to the Medicare Advantage Plan. (Advise your client to keep a copy for their records.)
- By sending their current Medicare Advantage Plan a letter, which includes their name and member ID number, requesting disenrollment. (Advise your client to keep a photocopy of the letter for their records.)

Your client's disenrollment request will be processed the same month it's received, effective for the first of the following month. The applicant must submit a termination letter to Blue Shield or ask their current Medicare Advantage Plan to call Blue Shield and provide us with a verbal confirmation that the applicant has been disenrolled from their plan.

Phone: **(800) 248-2341**
TTY: 711
Fax: (844) 266-1850

Mailing address:
Blue Shield of California
P.O. Box 948
Woodland Hills, CA 91365-9690

If your client has other health coverage

The law prevents Blue Shield from enrolling clients in a Medicare Supplement plan if they already have coverage (such as an existing Medicare Supplement or employer group plan) that the Blue Shield Medicare Supplement plan would duplicate. To help ensure that this doesn't happen, we will coordinate your client's effective date of coverage under his or her new Blue Shield Medicare Supplement plan to coincide with disenrollment from his or her previous health plan. First, we will notify your client by letter of his or her acceptance in a Blue Shield Medicare Supplement plan pending verification that his or her other health coverage has been terminated. Once your client has terminated his or her previous coverage, please submit proof of termination so we can finalize your client's acceptance.

Important: Your client should not disenroll from current coverage until coverage with Blue Shield has been approved.

Retroactive coverage

Clients may request that their effective date coincides with the date they received Medicare Part B if they have applied and been approved for coverage under Blue Shield's guaranteed-acceptance guidelines, are age 65 or older, and have received Medicare Part B within the previous three months.

Suspension

If a subscriber becomes entitled to Medi-Cal assistance, the benefits of the agreement will be suspended for up to 24 months. The subscriber must make a request for suspension of coverage within 90 days of Medi-Cal entitlement. Blue Shield shall return to the subscriber the amount of prepaid dues, if any, minus any monies paid by Blue Shield for claims made after the effective date of suspension. If the subscriber loses entitlement to Medi-Cal, the benefits of the agreement will be automatically reinstated as of the date of the loss of entitlement, provided the subscriber gives notice within 90 days of that date and pays the dues amount attributable to the retroactive period.

Blue Shield shall suspend the benefits and dues of the agreement for a subscriber when that subscriber:

- Is totally disabled as defined herein and entitled to Medicare benefits by reason of that disability;
- Is covered under a group health plan as defined in section 42 U.S.C. 1395y(b)(1)(A)(v); and
- Submits a request to Blue Shield for such suspension.

After all of the above criteria have been satisfied, benefits and dues of the agreement for the totally disabled subscriber will be suspended for any period that may be provided by federal law. For subscribers who have suspended their benefits under the agreement as specified above, and who subsequently lose coverage under their group health plan, the benefits and dues of the agreement will be reinstated only when the subscriber:

- Has notified Blue Shield of such loss of group coverage within 90 days after the date of such loss; and
- Pays the dues attributable to the period, effective as of the date of loss of group coverage.

If the above criteria have been satisfied, the effective date of the reinstatement will be the date of the loss of group coverage.

Blue Shield shall:

- Provide coverage substantially equivalent to coverage in effect before the date of suspension;
- Provide dues classification terms no less favorable than those which would have been applied had coverage not been suspended; and
- Not impose any waiting period with respect to treatment of pre-existing conditions.

Switching from one Blue Shield Medicare Supplement plan to a different Blue Shield Medicare Supplement plan

- *Applicants should never disenroll from current coverage until coverage in the new plan has been approved.* Members can always apply to transfer plans with one exception: transfers from open plans to closed plans are not available.
- Members must go through underwriting to transfer to an open plan that is richer than their existing plan. Clients must fill out an Application for Blue Shield of California Medicare Supplement Plans (Form C12687), including the Health Statement, and submit it to Blue Shield online, by mail, email, or fax for review and approval.

Members enrolled in Blue Shield 65 Plus℠ (HMO) may also apply for a Medicare Supplement plan. Please refer to the *Guaranteed Acceptance Guide* for specifics about transfers, applications, etc.

See page 15 for a complete list of plan transfer options.

Final determination client conversations

When your clients receive a final determination from Blue Shield, you may need to communicate some or all of the following information, depending on the circumstances:

Right-to-return policy

If your client finds that he or she is not satisfied with his or her contract, he or she may return it to:

Blue Shield of California
P.O. Box 272560
Chico, CA 95927-2560

When a client sends the contract back to us within 30 days of receipt, we will treat the contract as if it had never been issued and return all of your client's payments.

Denied coverage

If your client is denied coverage for a Medicare Supplement plan, we will automatically refund any payment submitted with the application. Refunds will be mailed within 7 to 10 business days.

Appeal of an underwriting decision

If your clients would like to appeal an underwriting decision, they may fax the appeal to: **(844) 266-1850**, Attention: Medicare. Email to: **MSInstall@blueshieldca.com**, or send via standard mail to:

Blue Shield of California
Attn: Medicare – Applications
P.O. Box 3008
Lodi, CA 95241-1912

(800) 248-2341

October 2019 transfer rules matrix and key

Free: Members can transfer between these open plans without Underwriting approval during the annual open enrollment guaranteed-acceptance period.

Apply: Member's application must be approved by Underwriting for transfer between these plans.

Effective October 1, 2019, Medicare Supplement Plans C, D, F, High Deductible F, and K are closing to new enrollment. Existing members are not affected, they will remain enrolled in these plans and no action is needed.

Transfer options for subscribers in 2010 standardized plans

Subscriber's current OPEN plan	Plan A	Plan N	Plan G	Plan F Extra
Plan F High Deductible	Apply	Apply	Apply	Apply
Plan K	Apply	Apply	Apply	Apply
Plan A	Free	Apply	Apply	Apply
Plan L	Free	Apply	Apply	Apply
Plan M	Free	Apply	Apply	Apply
Plan N	Free	Free	Apply	Apply
Plan B	Free	Free	Apply	Apply
Plan D	Free	Free	Apply	Apply
Plan G	Free	Free	Free	Apply
Plan C	Free	Free	Free	Apply
Plan F	Free	Free	Free	Apply
Plan F Extra	Free	Free	Free	Free
Plan F (with additional benefits)*	Free	Free	Free	Apply

Transfer options for subscribers in 1990 standardized or pre-standardized closed plans†

Subscriber's current CLOSED plan	Plan A	Plan N	Plan G	Plan F Extra
Plan F High Deductible	Apply	Apply		
Plan J High Deductible	Apply	Apply	Apply	Apply
Plan K	Apply	Apply	Apply	Apply
Plan A	Free	Apply	Apply	Apply
Plan L	Free	Apply	Apply	Apply
Plan B	Free	Free	Apply	Apply
Plan H (no Rx)	Free	Free	Apply	Apply
Plan E	Free	Free	Apply	Apply
Plan D	Free	Free	Free	Apply
Plan G	Free	Free	Free	Apply
Plan I (no Rx)	Free	Free	Free	Apply
Plan C	Free	Free	Free	Apply
Plan F	Free	Free	Free	Apply
Plan J	Free	Free	Free	Apply
Plan H (with Rx)	Free	Free	Free	Apply
Plan I (with Rx)	Free	Free	Free	Apply
Pre-standardized plans†	Free	Free	Free	Apply

* This is categorized as any Plan F (with additional benefits) offered by another Medicare Supplement.

† Pre-standardized plans include Blue Shield's pre-standardized plans, as well as other carriers' pre-standardized plans.

Per 1358.11 of the Knox Keene Act.

Medicare Supplement declinable conditions

Medicare Supplement plan applicants who have any of the following conditions may be declined without medical record review.

Declinable conditions list

Blastomycosis
Brain hemorrhage
Buerger's Disease
Bypass surgery, all cases
Cancer, in general, within three years and leukemia
Cardiac arrest and Hemiblock
Cardiomegaly
Carotid artery disease
Carotid bruit
Carotid endarterectomy
Cerebral embolism
Cerebral Palsy, moderate or severe
Cerebral thrombosis
Charcot-Marie-Tooth
Chemotherapy, current
Chondromalacia, systemic
Chronic Obstructive Pulmonary Disease, (COPD) severe, current smoker and emphysema
Cirrhosis of the liver
Claudication
Clubbed fingers
Congenital heart defects, unoperated
Congestive heart failure
Coronary artery disease, Ischemic heart disease
Craniopharyngioma
Cretinism
Crohn's Disease (Ileitis)
Cushing's Syndrome
Cyanosis
Cystic fibrosis
Decubitus ulcer
Dementia
Demyelinating disease
Diabetes with hypertension, neuropathy, retinopathy, renal, or circulatory complications, Ketoacidosis, or insulin pump, with amputation
Diabetes, insipidus
Dialysis, ESRD (end-stage renal disease)
Drug abuse/dependence
Dumping syndrome
Dwarfism
Eisenmenger's
Embolism
Endarterectomy
Esophageal varicosities
Friedreich's ataxia
Frohlich's syndrome
Glioma, Glioblastoma
Glomerulonephritis, progressive
Goodpasteur's syndrome
Hansen's disease
Heart valve stenosis
Hemiplegia
Hemolytic anemia, unoperated, acquired
Hemophilia A, B, or C
Hepatitis C or higher
Hepatomegaly, enlarged liver
Hodgkin's lymphoma
Huntington's chorea
Hydrocephalus
Hypertension, malignant
Hypertensive Renal Disease
Immunodeficiency disorder
Interstitial Cystitis
Kaposi's sarcoma
Kimmelstiel-Wilson Syndrome
Lupus Erythematosus, Systemic
Lymphosarcoma, within 3 years
Manic Depressive Disorder
Marfan's syndrome
Mediterranean anemia
Meningocele, present
Multiple myeloma
Multiple sclerosis
Muscular atrophy
Muscular dystrophy
Myasthenia gravis, non-localized
Narcolepsy
Nephritis, Chronic
Nephroblastoma (Wilm's tumor)
Nephrotic Syndrome
Neurofibromatosis
Neuroma, multiple
Non-Hodgkin's lymphoma
Osteitis Deformans
Osteogensis Imperfecta
Osteomyelitis, chronic
Pacemaker
Paget's Disease of the Bone
Paralysis – quadriplegia
Parkinson's Disease
Patent Ductus Arteriosus (PDA) unoperated
Pheochromocytoma, present
Pituitary gland disorders
Pneumoconiosis
Pneumocystis Carinii
Polyarteritis Nodosa
Polycystic kidneys
Proctitis, ulcerative within 5 years
Psoriatic arthritis
Psychosis
Pulmonary nodule, present
Pulmonary stenosis
Purpura, hemorrhagic
Reiter's Syndrome
Rheumatoid Arthritis, chronic, severe, extra articular manifestation, surgery contemplated
Scleroderma, recurrent
Sheehan Syndrome
Sick sinus syndrome
Silicosis
Sponge kidney
Syphilis, tertiary
Syringobulbia
Syringomyelia
Systemic lupus erythematous
Takayasu's Disease
Temporal arteritis
Tetralogy of Fallot, present
Thalassemia Major
Thrombocytosis
Thymoma, unoperated all cases, operated within 5 years
Tracheostomy
Transient Ischemic Attacks (TIA)
Transplants all cases, except corneal
Transposition of great arteries, unoperated
Turners syndrome
Ulcerative Colitis, within 5 years
Vasculitis
Ventricular Septal Defect (VSD), present
Von Recklinghausen's disease
Von Willebrand's disease
Waldenstrom's Macroglobulinemia
Wegener's granulomatosis
Wilm's tumor (nephroblastoma)

Dental and vision coverage

Submitting an application for Individual and Family dental and vision plans

Family dental and vision coverage with a medical plan

New health plan applicants do not need to complete a separate application for dental and vision coverage. When completing their health plan application, they can simply check the box for the dental and/or vision coverage they want. The application for health coverage and dental and vision coverage will be considered concurrently and, once approved, coverage effective dates will be the same for all.

If a member has already been enrolled in a Blue Shield individual and family health plan and would like to add dental and/or vision coverage, the member can either submit a completed dental or vision plan enrollment application (Form C36144) or apply online at **bscapply.com**.

Family dental and vision coverage without a medical plan

If your client is not enrolled in a Blue Shield health plan, but would like to enroll in a Blue Shield dental and/or vision plan, a Blue Shield specialty plan application (Form C36144) must be completed. Your clients can choose any of our dental, vision, or dental + vision plans: Dental PPO, Enhanced Dental PPO 25/500, Enhanced Dental PPO 50/1250, Enhanced Dental HMO $0, Dental HMO, Ultimate Vision 15/25/120*, Ultimate Vision 15/25/150,* or Specialty Duo℠ dental + vision package.*

Pediatric dental benefits

Pediatric dental care is an essential health benefit and is now embedded in non-grandfathered individual and family medical plans on and off exchange. The benefit covers dependent children through the end of the month the child turns 19.

Pediatric dental benefit features include:

- OOPM combined with medical up to $6,250.
- One combined ID card for medical/dental/vision.
- No deductible.
- Orthodontics, dentally necessary only, at 50% coinsurance.
- No waiting period for child(ren).
- Once the maximum out-of-pocket is reached, the plan pays 100% of services incurred.

Pediatric vision benefits

Pediatric vision care is an essential health benefit which is embedded in non-grandfathered individual and family medical plans. The benefit covers dependent children through the end of the month the child turns 19.

Eligibility for all vision plans

To be eligible for coverage, your client must reside in California.

Once coverage is approved, the coverage effective date will be the date requested by the applicant. If that date cannot be honored, coverage will begin as soon as possible. There is a 90-day waiting period before any benefits are available. This waiting period begins on the effective date of coverage.

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

Eligibility for all dental plans

To be eligible for coverage, your client must reside in California.

Once coverage is approved, the coverage effective date will be the date requested by the applicant for Dental PPO plans. If that date cannot be honored, coverage will begin as soon as possible.

Dental HMO plans will be assigned the 1st of the next month if the application is submitted between the 1st and 15th of the current month; or the 1st of the month following the next month if received between the 16th and the 31st of the month. For example, if the application for DHMO is received August 17, coverage will be effective October 1.

You can download dental and vision brochures with applications at **blueshieldca.com/producer/ifp/products/dental**, or request copies be mailed to you by calling Producer Services at **(800) 559-5905**.

Medicare Supplement plan member dental plans

New Medicare Supplement plan applicants do not need to complete a separate application for dental or dental + vision coverage. When completing their Medicare Supplement plan application, they can simply check the box for the dental coverage they want. The application for Medicare Supplement coverage and dental coverage will be considered concurrently and, once approved, coverage effective dates will be the same for both.

Members enrolling in Medicare Supplement Plan F Extra may elect to enroll in a dental plan but will not be eligible for the Specialty Duo dental + vision package plan as vision benefits are included within Plan F Extra coverage.

If a member has already been enrolled in a Blue Shield Medicare Supplement plan and would like to add dental or dental + vision coverage, the member can submit a Dental PPO Plan Enrollment Form for Blue Shield Medicare Supplement Plan Members (Form A43738-DS-FF). This application is available for download at **blueshieldca.com/producer**, by clicking on *Medicare Eligible* and then *Forms & Applications*.

Dental coverage without a medical plan

If your client is not enrolled in a Blue Shield Medicare Supplement plan, but would like to enroll in a Blue Shield dental plan, a Blue Shield specialty plan application (Form C36144) must be completed. Your clients can choose any of our dental or dental + vision plans: Dental PPO, Enhanced Dental PPO 25/500, Enhanced Dental PPO 50/1250, Enhanced Dental HMO $0, Dental HMO, or Specialty Duo dental + vision package.*

Eligibility for dental plans

To be eligible for coverage, your client must reside in California.

Once coverage is approved, it will become effective on the date requested by the applicant whenever possible. If that date cannot be honored, coverage will begin as soon as possible.

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

Individual term life insurance

Submitting an application

Individual term life insurance* is available on a standalone basis. Any and all family members can request life insurance. Family members may even select different amounts of coverage for themselves.

Requests for individual term life insurance can no longer be made on the IFP medical plan application. If your client would like to apply for individual term life insurance, an Application for Individual Term Life Insurance Coverage must be completed for each applicant applying for coverage. You can download the form from **blueshieldca.com/LifeApplication**, or request a copy by calling Producer Services at **(800) 559-5905**.

Your client simply completes the form indicating the amount of coverage and returns it to:

Blue Shield of California Life & Health Insurance Company
c/o HOVIN Underwriting Partners, Inc.
P.O. Box 249
Simsbury, CT 06070

If coverage is approved, the effective coverage date will be the first day of the month following approval.

Important: Your clients must also fill out the ITL Replacement section (Acknowledgement of Life Insurance Replacement Coverage) if they are replacing an existing life policy (located on page 4 of the application). This section needs to be signed and dated by both you and your client.

Eligibility

Coverage is available to the primary applicant (ages 1 to 64) of any Blue Shield Individual and Family health plan. Applicants under age 19 may not apply for amounts over $30,000.

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

Broker resources

The October 2019 edition of our *Application Eligibility and Underwriting Process Guide* makes selling Blue Shield easier than ever with these handy tools:

1. Application how-to tips
2. Key contacts and resources

Application how-to tips

New, non-grandfathered IFP plan applications should be submitted online via our IFP Quote & Apply tool, available at **bscapply.com**.

Medicare Supplement plan application can also be submitted online via our Medicare enrollment tool. Simply log in to Broker Connection, click *Medicare Eligible* in the menu and then select *Compare 2019 Plans & Enroll*. You will automatically be logged in to the enrollment site and can run quotes and apply on behalf of your clients.

Forms to use

- Dependent addition to existing grandfathered plans: Use Application for Blue Shield Individual and Family Grandfathered Health Plans only – Form C12900-RD.
- New enrollments and/or applications that require medical underwriting: Use Medicare Supplement plan application – Form C12687 (included in pre-sale kit, MedSupp-PR/PDP4).
- Existing Medicare Supplement members changing to a plan of equal or lesser value: Use Medicare Plan Transfer Application – Form MSP15571.
- Existing Medicare Supplement members wanting to add a dental or dental + vision plan: Use Dental PPO Plan Enrollment Form for Blue Shield Medicare Supplement Plan Members – Form A43738-DS-FF.

Checklist for completeness

You can help speed client applications through processing by doing a quick check to make sure each application is complete before you send it in. This checklist makes completed applications easy:

- ☐ Print clearly in all capital letters in black ink. Do not use pencil.
- ☐ Select a plan type.
- ☐ Complete gender and date of birth.
- ☐ Fill in all address information.
- ☐ Sign the application. All applicants age 18 or older must sign the application.
- ☐ Write the date next to the signature.
- ☐ Submit applications within 30 days of the applicant's signature date.

Once completed, have your clients submit the application to Blue Shield. Submit the application along with a personal check or money order, payable to Blue Shield, equal to one month's dues/premiums.

IFP-specific tips

Save time with our online application

Try our online IFP Quote & Apply tool and see how much easier it is to close sales fast and smoothly.

Where to submit dependent additions to grandfathered plans

Blue Shield of California
Attn: I&B – Applications
P.O. Box 3008
Lodi, CA 95241-1912

Fax: (888) 386-3420

Email: **IFPapplications@blueshieldca.com**

Medicare Supplement plan-specific tips

These tips apply to applications for any of the following plans: A, F Extra, G, and N.

Advice to clients

Please advise your clients to truthfully and completely answer all questions about their medical and health history. They should carefully review their completed applications before signing to be certain that each section has been properly recorded.

In addition to the general tips provided in this section, be sure to have clients who are applying for a Medicare Supplement plan do the following:

- Read all the instructions carefully.
- Print clearly in all capital letters in black ink – do not use pencil.
- Retain a copy of each page of the application for their files.

Completeness check

Additional items to check for Medicare Supplement plan applications:

- ☐ Health coverage information
- ☐ Subscriber number and prior healthcare company name
- ☐ Replacement form for applicants with current Medicare Supplement plan coverage
- ☐ Statement of health (except if guaranteed acceptance)

Where to submit

Submit new enrollment and transfer Medicare Supplement plan applications to:

Blue Shield of California
Attn: Medicare – Applications
P.O. Box 3008
Lodi, CA 95241-1912

Fax: (844) 266-1850

Email: **msinstall@blueshieldca.com**

Sales support

Blue Shield of California is dedicated to helping you grow your IFP business by incorporating Blue Shield plans into your portfolio. Blue Shield can provide training on Blue Shield IFP plans via webinars and teleconferences, and help answer any questions you might have about Blue Shield products and processes.

Key contacts and resources

On these pages you'll find all the ways you can contact us, and whom to ask for what. For fast service, use the phone or fax number, address, or email address specific to your question.

Individual and Family Plans

	Email	Phone	Fax
New applications – submissions	IFPapplications@blueshieldca.com		(888) 386-3420
Pend information – submissions, SEP supporting documents	eligibilityverification@blueshieldca.com	(800) 559-5905	(888) 386-3420
Application status	ProducerServices@blueshieldca.com	(800) 559-5905 Mon – Thurs: 8 a.m. – 6 p.m. Friday: 9 a.m. – 5 p.m. Automated information available after business hours	(209) 371-5830
Information sources Dues/premiums payment information Delinquent report fax-back requests Underwriting guidelines Commissions information/issues Product information Supply orders Broker correspondence	ProducerServices@blueshieldca.com	(800) 559-5905	(209) 371-5830
Electronic claims submission help desk		(800) 480-1221	
Dental Member Services		(888) 271-4880	

IFP addresses

IFP applications – Dependent additions to grandfathered plans Application updates Underwriting requests Letters from members/subscribers	Blue Shield of California Attn: I&B – Applications P.O. Box 3008 Lodi, CA 95241-1912	(800) 559-5905	

Medicare Supplement plans

	Email	Phone	Fax
New applications – submissions	msinstall@blueshieldca.com	(800) 559-5905	(844) 266-1850
Pend information – submissions	msinstall@blueshieldca.com	(800) 559-5905	(844) 266-1850
Guaranteed acceptance applications – submissions			(844) 266-1850
Application status	ProducerServices@blueshieldca.com	(800) 559-5905 Mon – Thurs: 8 a.m. – 6 p.m. Friday: 9 a.m. – 5 p.m. Automated information available after business hours	(209) 371-5830
Information sources Dues/premiums payment information Underwriting guidelines Commissions information/issues Product information Supply orders Broker correspondence	ProducerServices@blueshieldca.com	(800) 559-5905	(209) 371-5830
Electronic claims submission help desk		(800) 480-1221	
	Address		
Medicare Supplement plan applications Correspondence about Medicare Supplement plans	Medicare Supplement Department P.O. Box 3008 Lodi, CA 95241-1912		

General addresses

License updates Errors and omissions updates New appointment paperwork Broker of record changes Commissions issues New group quotes Broker information updates	Blue Shield of California Producer Services P.O. Box 272500 Chico, CA 95927-2500

Online resources

Plans and rates • Product information including plan summaries • Underwriting guidelines • Applications and other forms **Tools** • Quoting • Online application • Application status • Client list • Supply ordering system • Advertising resources to help promote your business **Rewards** • Commission structures • Bonus programs **News** • Product and company information • Policy announcements • Press releases	**blueshieldca.com/producer**

For members

Blue Shield of California Network Provider Directory	**blueshieldca.com**
Blue Shield Life Network Provider Directory	**bscalife.com**
Health Insurance Counseling and Advocacy Program (HICAP): provides health insurance counseling for California senior citizens. Call the HICAP toll-free telephone number for a referral to the local HICAP office. HICAP is a service provided free of charge by the state of California.	(800) 434-0222
Medicare Supplement plan member customer service	(800) 248-2341 TTY: 711
IFP and Medicare Supplement member dues/premiums payment address	Blue Shield of California Attention: Plan Payment P.O. Box 54530 Los Angeles, CA 90054-0530
Dental Member Services	(888) 271-4880 **yourdentalplan.com/bsca**
Dental HMO claims address	Blue Shield of California Attention: Claims Unit P.O. Box 272540 Chico, CA 95927-2540
Dental PPO claims address	Blue Shield of California P.O. Box 272590 Chico, CA 95927-2590
Enhanced dental services for pregnant women	Blue Shield of California Periodontal Coverage for Women During Pregnancy 425 Market Street, 12th Floor San Francisco, CA 94105