blue of california

Coverage for every size of small business

2018 small business packages for 1–100 employees

Effective April 1, 2018


DINER
ANTIQUES

Helping California's small businesses grow with the right health coverage

Whether it's a budding one-person operation or a booming 100-employee enterprise, small businesses across California share the same need for a healthy and productive workforce.

That's why we offer a wide range of small business health plans with solutions for controlling costs and promoting a healthy workforce.

Inside, you'll find the latest updates to our 2018 small business portfolio, including:

- **The addition of Tandem PPO Network – we're proud to offer more flexibility with six new PPO plans.**
- **Growing opportunities in our Trio ACO HMO Network with new providers and covered counties.**
- **More options for specialty benefits – dental, vision,* and life.***

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This way to access high-quality health care

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

Network choice and breadth

Enhance employee satisfaction to protect your bottom line

Offer wellness and discount programs (that you'll really use!)

Offer a more comprehensive benefits package with dental, vision,* and life insurance*

Trusted for more than 75 years

Why choose Blue Shield?

* Blue Shield vision and life insurance plans are underwritten by Blue Shield of California Life & Health Insurance Company.

Choose the option that best suits your business

At Blue Shield of California, our mission is to ensure all Californians have access to high-quality health care at an affordable price. We offer your employees access to a broad range of hospitals, doctors, specialists, pharmacies, dental and vision professionals, and other providers.

Blue Shield offers two packages to small businesses outside of Covered California for Small Business, as described in this brochure. You select a package and then choose plans within that package to offer your employees and their dependents. You can offer plans from the **Off-Exchange Package** or the **Mirror Package**, but not both.

The Blue Shield Off-Exchange Package for Small Business

This package includes up to 37 plans to offer employees:

- Preferred provider organization (PPO) plans
- Health savings account (HSA)-compatible PPO high-deductible health plans (HDHPs)
- Health maintenance organization (HMO) plans

Our health plans are available at a variety of metal levels. Each metal level – Platinum, Gold, Silver, and Bronze – offers a different level of coverage. The HMO plans offer a choice in the size of provider networks through the Access+ HMO® (full network), Local Access+ HMO (narrow network), and Trio HMO (accountable care organization network) plans, so that you can pick the option that best suits your company.

The Blue Shield Mirror Package

This package offers up to seven plans: PPO plans at every metal level and our Trio HMO plans at the Platinum, Gold, and Silver metal levels. The Mirror Package offers the same standardized plans directly from Blue Shield that are offered on Covered California for Small Business.

Note: Federal tax credits are available through Covered California for Small Business to those small business employers that qualify and purchase their coverage on Covered California for Small Business. Talk to Covered California for Small Business (877) 453-9198, your plan representative, or your broker to discuss your options.

Participation requirements

We're relaxing the participation requirement to 25% for groups with five or more enrolled employees, less than our already low requirement of 65% and among the lowest in the industry.

Businesses sometimes want to purchase medical plans from different carriers. However, smaller businesses typically can't meet minimum participation requirements. This lowered 25% requirement allows small businesses to purchase a medical plan from Blue Shield alongside another carrier's medical plan with more lenient underwriting participation rules. Please note: Only one carrier is allowed to be written alongside a Blue Shield plan. Healthcare exchanges are not eligible for this promotion.

A group must have at least 25% of the total number of eligible employees enroll in a Blue Shield healthcare plan with no fewer than five.

Let's use this example:

		Sample company	Your company
1	Total number of employees eligible for coverage	**24**	
2	Number of employees with valid waivers (Medicare, MediCal, military, covered by spouse's group coverage only)	**4**	
3	Number of eligible employees (subtract line 2 from line 1)	**20**	
4	Multiply the number of eligible employees by .25 to determine whether minimum participation is met.	**20 x .25 = 5** As long as 5+ eligibles enroll for health coverage, the participation requirement is met.	

If the group contributes 100% of premiums for medical coverage, then 100% of eligible employees must enroll (except those waiving due to other group coverage through another employer).

Trio HMO plans

We're waiving our participation requirements for Trio-only membership for groups of 1 to 100 eligible employees. No more counting or calculating to meet membership minimums. Just select Trio plans only on the Master Group Application and a new group can enroll with Blue Shield with as few as a single member.*

Mirror Package participation requirements

General participation requirements:

A minimum of one eligible employee and at least 70% of all eligible employees must enroll in the Blue Shield plan(s), including any specialty benefits plans offered. Life insurance plans require a minimum of two eligible employees.

Specialty plan participation requirements

Specialty benefits plan participation requirements are the same as the off-exchange medical plan participation requirement and have been reduced from 65% to 25% of the total number of employees enrolled. If a group contributes 100% of premiums for specialty benefits,† then 100% of eligible employees must enroll (except for those waiving due to other group specialty coverage through another employer). Blue Shield dental, vision,‡ and life‡ insurance plans must be the sole carrier for these plans even, when Blue Shield medical plans are offered alongside another carrier's medical plans.

The Blue Shield of California Off-Exchange Package for Small Business was designed to make it easy for you to offer quality healthcare coverage to your employees.

All other Blue Shield of California underwriting guidelines and eligibility requirements still apply. Groups changing plans within the first 30 days must meet Blue Shield participation requirements to still be eligible for coverage. The waiver of participation requirements is guaranteed only for the contract term. Blue Shield reserves the right to apply participation requirements on renewal.

* Groups selecting Trio only for their medical health plans can also add dental or vision coverage with the same minimum participation requirements waived.

† When employer contribution for life insurance is 100%, 100% enrollment is required; no waivers are permitted, even for coverage through another employer.

‡ Blue Shield vision and life insurance plans are underwritten by Blue Shield of California Life & Health Insurance Company.

Coverage for the entire family

Family health plan rating

Family rating applies to all of our small business package offerings

For an employee with health plan coverage that covers more than three dependent children under the age of 21, the total family rate for that coverage will include the rates for the employee, his or her spouse or domestic partner and a maximum of three* of the oldest covered children. Additional dependent children (under 21) will have a rate of $0.

Here is an example to illustrate this scenario. (Rates are shown for example only and do not reflect the rates of any products offered by Blue Shield.)

Family coverage: subscriber, dependent spouse/domestic partner, four dependent children		
	Lisa Williams, Adult 1: 47 years old	Rate: $290
	David Williams, Adult 2: 46 years old	Rate: $280
	Laura Williams, Child 1: 17 years old	Rate: $178
	John Williams, Child 2: 14 years old	Rate: $133
	Jeff Williams, Child 3: 9 years old	Rate: $133
	Lucas Williams, Child 4: 7 years old	**Rate: $0**

Dental and vision plan tier rating

Small business dental and vision plans are rated on a tier-level basis. The following four tiers apply to dental and vision rating: Employee Only, Employee + Spouse or Domestic Partner, Employee + Children, and Family.

Pediatric vision and dental coverage is included with all Blue Shield small business medical plans

PPO and HSA Blue Shield medical plans include PPO pediatric dental and vision coverage for age-eligible members. HMO Blue Shield medical plans include network-only PPO pediatric dental and vision coverage for age-eligible members. Both pediatric dental and vision benefits provided by a non-network provider for non-emergency services are not eligible for coverage under Blue Shield HMO medical plans.

Supplemental infertility coverage

Blue Shield offers supplemental coverage for infertility treatment for off-exchange plans. This supplemental coverage can be purchased only with a Blue Shield health plan.

Please see page 35 for more details.

* If a member has any dependent children over the age of 21, they would not be counted as part of the three additional dependent children. They would be charged at the rate for their age.

Access to care

From routine checkups to emergencies and everything in between, Blue Shield gives members access to a quality network of healthcare providers. Here's how members can find the most cost-effective care when they need it, where they need it.

NurseHelp 24/7℠ $$$$
Immediate, non-emergency health advice from a registered nurse over the phone. No cost or copay for Blue Shield members.

Teladoc $$$$
Board-certified, licensed doctors available 24/7 by phone or video to treat non-emergency medical issues and provide prescriptions when needed.

Primary care physician (PCP) $$$$
A member's main healthcare provider for routine medical needs.

Urgent care $$$$
Licensed medical doctors, nurses and medical personnel on call for walk-in, non-emergency care.

CVS MinuteClinic™ $$$$
Walk-in health care at CVS retail locations by board-certified nurse practitioners.

BlueCard® $$$$
Access to covered services when a member and their family are away from home.

Heal™ $$$$
On-demand physician house calls to a member's house, office, or hotel.

Emergency room $$$$
Immediate care for emergencies.

Telehealth $$$$
Rural and urban access to specialists via interactive video teleconferencing.

These providers available to all members

These providers available to PPO members

Go to **blueshieldca.com/care** to see all care options in one place.

911 If you are experiencing an emergency, call **911** immediately.

Compare care options

Blue Shield members have many different care options available to them.*

Providers available to all Blue Shield members:

Provider	Best for	Available	More info
NurseHelp 24/7	Around the clock, non-emergency health advice over the phone. Can be used for: Minor illnesses and injuries, chronic conditions, medical tests, questions on medications or preventive care.	24/7	Call **(877) 304-0504** or visit **blueshieldca.com/nursehelp**.
Teladoc	When it's a non-emergency and a doctor is needed. When a member is away from home or when their primary care provider is not available. Can be used for: Respiratory infections, colds, sinus infections, allergies, rashes, skin problems, abdominal pains/cramps, joint pain, and many others.	24/7	Call **(800) 835-2362** or visit **teladoc.com/bsc**.
Primary care physician (PCP)	The main healthcare provider to treat common medical conditions and provide preventive care and referrals to a specialist if needed. Can be used for: Annual checkups, physical exams, common illnesses and injuries.	Varies (check with the PCP's office)	Visit **blueshieldca.com/fad**.
Urgent care†	When a member's doctor is not available and in-person, non-emergency care is needed. Can be used for: Respiratory infections, colds, infections, allergies, sprains, minor cuts and scrapes, nausea, vomiting, and diarrhea. Walk-in appointments.	Typically extended hours (check with the local provider)	Visit **blueshieldca.com/fad**.
BlueCard	Urgent and emergency care services while traveling. Can be used for: Urgent and emergency care outside of California and overseas.	Varies by provider	If within the United States, call **(800) 810-BLUE** or visit **provider.bcbs.com**. If overseas, call **(804) 673-1177** or visit **bcbsglobalcore.com**.
Emergency room	Life-threatening emergencies. Should be used for: Any life-threatening or disabling condition or injury.	Typically 24/7 (check with the local ER)	Call **911** or go immediately to the nearest ER.

Providers available to Blue Shield PPO members only:

Provider	Best for	Available	More info
CVS MinuteClinic	Non-emergency conditions. Can be used for: Immunizations, allergies, infections, coughs, flu-like symptoms.	Every day, including evenings and weekends	Visit **www.minuteclinic.com** for locations.
Heal	Non-emergency care when you can't travel to a facility and need a doctor to come to you. Can be used for: Urgent care, primary care, preventive care, flu shots, and screenings.	By appointment in select urban areas	Call **(844) 644-4325** or visit **www.getheal.com**.
Telehealth	High-quality specialist care without having to travel far away to appointments. Can be used for: Specialist care and services.	At Adventist Health clinic locations	Call **(866) 832-8218** or visit **blueshieldca.com/telehealth**.

* For more information and details on benefits or covered services, members should refer to their *Evidence of Coverage* (EOC) or call the customer service number that appears on their Blue Shield member ID card.

† Before HMO members visit an urgent care center, they may be required to call their doctor's office each time they seek care. HMOs may require the doctor's office to provide authorization before the member goes to the urgent care center. HMO members must receive care at an urgent care center that is affiliated with their doctor's medical group or IPA, or the HMO plan may not cover the services received.

Teladoc, Heal, and Adventist Health are independent entities that administrate services on behalf of Blue Shield of California.

Heal is a trademark of Burrito Labs, Inc.

Value-added programs

wellvolution

Wellvolution® is a next-generation wellness program that connects members to programs that blend socializing, fun activities and rewards.

All Blue Shield small business plans include Wellvolution's core services to help members age 18 and older live healthier lives. These services include helping employees measure their well-being, addressing specific areas of concern such as diabetes prevention, and engaging in purposeful, daily activities. Package elements include:

Well-Being Assessment

This assessment goes beyond the typical health survey by measuring overall outlook, emotional and physical health, healthy behaviors, work environment, and access to health/life resources.

Daily Challenge

Daily Challenge® educates and inspires members to do the little things that add up to lasting health and well-being. Members receive a daily email with small tasks that help improve physical health, encourage healthy behavior, boost emotional health, and more.

Walkadoo

Walkadoo® includes an easy-to-use mobile app that provides a realistic and convenient way to encourage more movement each day. Trio HMO subscribers receive a Fitbit Zip® activity tracker at no extra charge.

QuitNet

QuitNet® offers online and mobile support from experts and peers with personalized emails and texts. QuitNet now includes nicotine replacement therapy (NRT) at no additional cost.

Diabetes Prevention Program

The Diabetes Prevention Program can help members lose weight, adopt healthier habits, and reduce the risk of developing type 2 diabetes.

Teladoc – A new and convenient way to access care

Teladoc is now included in all of our small business plans. Teladoc's U.S. board-certified doctors are available 24/7/365 to resolve non-emergency medical issues through phone or video consults.

Getting started is as easy as 1, 2, 3 for members!

1. Set up an account.
2. Provide medical history.
3. Request a consult.

Teladoc offers unlimited visits and is not subject to the deductible for all **small business HMO and Full PPO plans with a $5 copay**. Small business PPO Savings plans have a $40 copay prior to the deductible, and once the deductible is met, the $5 copay will apply.

Visit **Teladoc.com/bsc** to learn more.

Identity protection services

Eligible* Blue Shield members can get identity protection services such as identity repair assistance, identity theft insurance, and credit monitoring at no extra charge.

Members can access these services by calling **(855) 904-5733**, 6 a.m. to 6 p.m., Monday through Saturday or 24/7 at **blueshieldca.allclearid.com**.

* Due to current laws and regulations, members of Blue Shield Federal Employee Programs, Medicare Advantage HMO Plan, or Medicare Prescription Drug Plan are not eligible to receive this offer.

The Diabetes Prevention Program is provided by Solera Health, an independent company.

Keeping employees well with great programs

Online registration provides members with access to valuable online tools and resources to manage their health.

Wellness discount programs*[1] – Blue Shield offers a variety of member discounts on massage sessions, gym memberships, LASIK eye surgery, and even a popular weight management program. Online discounts of up to 40% off retail items (many with free shipping) include vitamins and supplements, yoga and fitness equipment, and much more.

- **Discount Provider Network**[2] – 20% off the published retail prices when using a participating provider in the Discount Vision Program network for exams, frames, lenses, and more.
- **Alternative Care Discount Program** – 25% off usual and customary fees for acupuncture, massage therapy and chiropractic services, plus discounts on health and wellness products, with free shipping on most items.
- **MESVision Optics** – Competitive prices on contact lenses,[3] sunglasses, readers, and accessories. Free shipping on orders over $50.
- **QualSight LASIK** – Savings on LASIK surgery at more than 45 surgery centers in California. Services include pre-screening, a pre-operative exam, and postoperative visits.
- **NVISION Laser Eye Centers** – 15% discount on LASIK surgery from experienced surgeons with offices in Southern California and Sacramento.
- **Hearing-aid discount** – 30% to 60% off manufacturers' suggested retail prices on major brands through EPIC Hearing Service.
- **Weight Watchers** – Discounts on three- and 12-month subscriptions, monthly passes, and at-home kits.
- **24 Hour Fitness** – Waived enrollment, processing and initiation fees, and discounts on monthly membership dues.
- **ClubSport and Renaissance ClubSport** – 60% discount on enrollment with a month-to-month agreement. Enrollment fees are waived with a 12-month agreement. There is a one-time $25 processing fee.
- **NurseHelp 24/7** – Members can speak with registered nurses anytime, day or night, and get answers to health-related questions, or go online to have a one-on-one consultation.
- **Condition Management Program** – This program offers nurse support as well as education and self-management tools for members with asthma, diabetes, coronary artery disease, heart failure, and chronic obstructive pulmonary disease.

* Discount program services are not a covered benefit of Blue Shield health plans and none of the terms or conditions of Blue Shield health plans applies. See endnotes on page 38.

Rating region standardization

There are 19 standardized rating regions in California.

Blue Shield bases the rating on the employer location by ZIP code for all plans, including medical, dental and vision plans.

This map of California breaks out the standardized rating regions applicable to all of our small business plan packages:

- **Rating region 1** **Rural North/Sierra**
  Alpine, Del Norte, Siskiyou, Modoc, Lassen, Shasta, Trinity, Humboldt, Tehama, Plumas, Nevada, Sierra, Mendocino, Lake, Butte, Glenn, Sutter, Yuba, Colusa, Amador, Calaveras, Tuolumne
- **Rating region 2** **Wine Country**
  Napa, Sonoma, Solano, Marin
- **Rating region 3** **Greater Sacramento Region**
  Sacramento, Placer, El Dorado, Yolo
- **Rating region 4** **San Francisco**
  San Francisco
- **Rating region 5** **Contra Costa**
  Contra Costa
- **Rating region 6** **Alameda**
  Alameda
- **Rating region 7** **Santa Clara**
  Santa Clara
- **Rating region 8** **San Mateo**
  San Mateo
- **Rating region 9** **Monterey Bay**
  Santa Cruz, Monterey, San Benito
- **Rating region 10** **Central Valley North**
  San Joaquin, Stanislaus, Merced, Mariposa, Tulare
- **Rating region 11** **Central Valley South**
  Madera, Fresno, Kings
- **Rating region 12** **South Coast**
  San Luis Obispo, Santa Barbara, Ventura
- **Rating region 13** **Southern Desert**
  Mono, Inyo, Imperial
- **Rating region 14** **Kern**
  Kern
- **Rating region 15** **Los Angeles East**
  Los Angeles ZIP codes starting with 906-912, 915, 917, 918, 935
- **Rating region 16** **Los Angeles West**
  Los Angeles not including ZIP codes above
- **Rating region 17** **Inland Empire**
  San Bernardino, Riverside
- **Rating region 18** **Orange County**
  Orange County
- **Rating region 19** **San Diego**
  San Diego

Off-Exchange Package for Small Business

Complete your coverage with dental, vision, and life. See page 29.

Our plan names align closely with Covered California for Small Business. The names make it easy to understand the benefits each plan offers.

The plan names follow this format:

Metal tier + network name + product type + deductible + copay + suffix (off-exchange)

Blue Shield of California Off-Exchange Package for Small Business

HMO plans available on the Access+, Local Access+, or Trio ACO networks	PPO plans are available with Full or Tandem networks	HSA-compatible HDHP plans are available with the Full PPO Network
Platinum Access+ HMO 0/25 OffEx	Platinum PPO 0/10 OffEx	Silver Full PPO Savings 2000/20% OffEx
Platinum Local Access+ HMO 0/25 OffEx	Platinum Tandem PPO 0/10 OffEx	Bronze Full PPO Savings 4300/40% OffEx
Platinum Trio HMO 0/25 OffEx	Platinum PPO 250/15 OffEx	Bronze Full PPO Savings 6550 OffEx
Platinum Access+ HMO 0/20 OffEx	Platinum Tandem PPO 250/15 OffEx	
Platinum Local Access+ HMO 0/20 OffEx	Gold PPO 0/20 OffEx	
Platinum Trio HMO 0/20 OffEx	Gold PPO 450/30 OffEx	
Platinum Access+ HMO 0/30 OffEx	Gold PPO 750/30 OffEx	
Platinum Local Access+ HMO 0/30 OffEx	Gold Tandem PPO 750/30 OffEx	
Platinum Trio HMO 0/30 OffEx	Gold PPO 1200/35 OffEx	
Gold Access+ HMO 500/35 OffEx	Silver PPO 2000/45 OffEx	
Gold Local Access+ HMO 500/35 OffEx	Silver Tandem 2000/45 OffEx	
Gold Trio HMO 500/35 OffEx	Silver PPO 1700/55 OffEx	
Gold Access+ HMO 1700/35 OffEx	Silver Tandem PPO 1700/55 OffEx	
Gold Local Access+ HMO 1700/35 OffEx	Bronze PPO 3750/65 OffEx	
Gold Trio HMO 1700/35 OffEx	Bronze Tandem PPO 3750/65 OffEx	
Silver Access+ HMO 1750/55 OffEx	Bronze PPO 5700/60 OffEx	
Silver Local Access+ HMO 1750/55 OffEx		
Silver Trio HMO 1750/55 OffEx		

Thirty-seven plans to choose from

The Blue Shield of California Off-Exchange Package for Small Business has 37 plans, 18 of which are HMO plans with a choice of the Access+, Local Access+, or Trio ACO HMO networks. Employers located in certain California counties whose eligible employees live or work in the Local Access+ HMO service area have the option of choosing any of the Local Access+ HMO plans or any of the Access+ HMO plans, but not both. Customers may, however, offer Access+ HMO plans with Trio HMO plans. The Trio HMO plans have the same benefits as our Access+ HMO plans. Please review the Benefit Summary Guide (A16609) for detailed information regarding the Access+ HMO and Local Access+ HMO service areas.

Off-Exchange Package for Small Business (continued)

You may now offer Tandem PPO plans alongside Full PPO plans for added savings and flexibility.

PPO plans

Our off-exchange PPO plans are available with our Full PPO Network or our Tandem PPO Network and include providers in all 58 California counties. Our off-exchange PPO plans also offer the flexibility for your employees to see non-network providers. Direct access to network physicians and specialists means no referrals are necessary. These plans also come with a wide range of deductible options.

Tandem PPO plans*

Tandem is a statewide, high-performing PPO network, providing the same plan benefits as the Full PPO plans at a lower price.

The Tandem PPO Network is a subset of our Full PPO Network. Statewide, 60% of Blue Shield providers are included, with access to doctors in all areas of specialty. Tandem includes all Blue Shield Full PPO Network hospitals.†

Tandem members are assigned a primary care physician to help manage their care, but still have the freedom to see any provider in the network without a referral.

HSA-compatible HDHP plans‡

Many small businesses opt for high-deductible PPO plan coverage for their employees. Deductibles are higher, but monthly rates are lower, and the plans come with an option of opening a health savings account (HSA) to help pay for qualified medical expenses.

Match your HSA-compatible plan with HealthEquity

Customers may now offer HealthEquity as the administrator for all of our HSA-compatible plans:

- Silver Full PPO Savings 2000/20% OffEx
- Bronze Full PPO Savings 4300/40% OffEx
- Bronze Full PPO Savings 6550 OffEx

HMO plans

Nine of our plans for small business offered off exchange are HMO plans. These plans are available with one of three HMO provider network options: Access+ HMO, Local Access+ HMO, or Trio ACO HMO networks. All specialties and levels of care are included in all three plans:

- The Access+ HMO plan gives members access to more than 38,000 doctors and 320 hospitals.
- The Local Access+ HMO plan gives members access to more than 17,000 doctors and 320 hospitals.
- The Trio HMO plan is available in 24 counties and gives members access to 10,000 doctors from the Access+ provider network.

* If a member receives services from a non-participating provider, Blue Shield's payment for that service may be substantially less than the amount billed. The subscriber is responsible for the difference between the amount Blue Shield pays and the amount billed by the non-participating provider.

† Includes Sutter Health hospitals only where necessary to achieve minimum coverage requirements (Alameda and Del Norte counties).

‡ Although most consumers who enroll in an HDHP are eligible to open an HSA, members should consult with a financial adviser to determine if an HSA/HDHP is a good financial fit for them. Blue Shield does not offer tax advice or HSAs. HSAs are offered through financial institutions. For more information about HSAs, eligibility and the law's current provisions, consumers should ask their financial or tax adviser. HSA plan features may vary by institution and may be subject to change by those institutions.

Off-exchange HMO plans

You may offer Trio HMO and Access+ HMO together for added savings and flexibility.

Access+ and Local Access+ HMO plans

Our Access+ HMO plans offer groups the largest HMO network in our portfolio. Local Access+ HMO plans offer all the same benefits of our Access+ HMO plans within a select (smaller) network, resulting in a lower rate. Depending on location, the Local Access+ HMO plans may result in more savings than Access+ HMO plans.

Trio HMO plans

The Trio HMO option may be the perfect answer for the small business that wants to offer comprehensive, high-quality coverage at an even more affordable rate than the Local Access+ HMO plan. With coverage in 24 counties, the Trio HMO plan offers a more integrated and coordinated care model at a lower rate. Remember, as of October 1, 2016, small businesses can offer Trio HMO alongside Access+ HMO, allowing for more options and savings.

Trio HMO delivers

With Trio HMO, we've helped simplify health care and reduce costs.

Plans are powered by our accountable care organizations (ACOs), which are made up of a network of **local doctors, specialists and hospitals**.

Through coordination, care is delivered more efficiently, which helps to **lower premiums and improve patient experience**.

Trio also includes some unique features for members such as one-stop customer service and a Fitbit® wireless activity tracker at **no extra cost**.

Off-exchange HMO plans (continued)

Trio bonus features

Trio HMO plans come with these **valuable features** not included with other HMO plans:

Shield Concierge

Shield Concierge is our integrated service model designed to provide a personalized member experience.

Enhanced wellness package

With Trio's Wellvolution package, members can get a Fitbit wireless activity tracker at no extra cost.†

Trio savings

Our ACOs have saved our members and employers **hundreds of millions of dollars** since 2010. Plus, the lower cost trends of Trio HMO can help stabilize any annual price increases.

* Aggregate cost savings and trends measured from ACO inception to September 2016. Utilization statistics measured from inception to September 2016. Trend utilization statistics adjusted for changes in population health.

† Fitbit device is available only to Trio subscribers age 18 and older.

Off-exchange HMO plans (continued)

Purchasing an HMO plan

To purchase an Access+ HMO, Local Access+ HMO, or Trio HMO plan:

1. The small business employer must be located in the plan's service area, and
2. The eligible employees must live or work in the service area.

County listing for Access+ HMO, Local Access+ HMO, and Trio HMO			
HMO plans with the Access+ HMO Network are available in the following counties:		**HMO plans with the Local Access+ HMO Network are available in the following counties:**	**Trio HMO is available in the following counties:**
Alameda	Sacramento	Contra Costa*	Alameda
Butte	San Bernardino*	Kern*	Contra Costa
Contra Costa	San Diego*	Los Angeles*	El Dorado*
El Dorado	San Francisco	Marin	Kern*
Fresno	San Joaquin	Orange	Los Angeles*
Imperial	San Luis Obispo	Riverside*	Marin*
Kern	San Mateo	Sacramento*	Nevada*
Kings	Santa Barbara	San Bernardino*	Orange
Los Angeles	Santa Clara	San Diego*	Placer*
Madera	Santa Cruz	San Francisco	Riverside*
Marin	Solano	San Luis Obispo	Sacramento*
Merced	Sonoma	San Mateo*	San Bernardino*
Nevada*	Stanislaus	Santa Clara	San Diego*
Orange	Tulare	Santa Cruz	San Francisco
Placer	Ventura	Sonoma	San Joaquin
Riverside	Yolo	Stanislaus	San Luis Obispo*
		Ventura*	San Mateo
		Yolo	Santa Clara
			Santa Cruz
			Solano*
			Stanislaus*
			Tulare*
			Ventura*
			Yolo*

* Partial county availability.

If you are an employer located in certain California counties whose eligible employees live or work in the Local Access+ HMO service area, you have the option of choosing the Local Access+ HMO plans or the Access+ HMO plans, but not both. You may, however, offer Access+ HMO plans with Trio HMO plans. The Trio HMO plans have the same benefits as our Access+ HMO plans.

Enrolled employees and their dependents must live or work in the Trio HMO service area to be eligible for coverage.

Please visit **blueshieldca.com/ACO** for the latest service area information for these plans.

Off-exchange HMO plans (continued)

All HMO plans available on the Access+, Local Access+ or Trio ACO networks. Groups can offer Access+ and Trio plans together. Local Access+ plans cannot be offered alongside Access+ or Trio plans.

Benefits		PLATINUM COVERAGE			GOLD COVERAGE		SILVER COVERAGE
		Platinum HMO 0/20 OffEx	**Platinum HMO 0/25 OffEx**	**Platinum HMO 0/30 OffEx**	**Gold HMO 500/35 OffEx**	**Gold HMO 1700/35 OffEx**	**Silver HMO 1750/55 OffEx**
Calendar-year facility deductible		None	None	None	$500 per individual/ $1,000 per family	$1,700 per individual/ $3,400 per family	$1,750 per individual/ $3,500 per family
Calendar-year out-of-pocket maximum		$1,350 per individual/ $2,700 per family	$1,700 per individual/ $3,400 per family	$2,250 per individual/ $4,500 per family	$5,600 per individual/ $11,200 per family	$6,550 per individual/ $13,100 per family	$7,000 per individual/ $14,000 per family
Office visit – primary care physician		$20 per visit	$25 per visit	$30 per visit	$35 per visit	$35 per visit	$55 per visit
Preventive health benefits		No charge	No charge	No charge	No charge	No charge	No charge
Inpatient hospitalization		$500 per admission	$250 per day, up to 3 days per admission	$500 per day, up to 4 days	20%[2]	20%[2]	40%[2]
Emergency room services not resulting in admission		$200 per visit	$250 per visit	$250 per visit	$250 per visit (after deductible)	$200 per visit (after deductible)	40% per visit (after deductible)
Prenatal and preconception physician office visits		No charge	No charge	No charge	No charge, deductible waived	No charge, deductible waived	No charge, deductible waived
Calendar-year pharmacy deductible		None	None	None	None	$300 per individual/ $600 per family	Integrated with medical deductible
Retail prescriptions[1,4,5] (up to a 30-day supply)	**Tier 1 drugs**	$5 per prescription	$5 per prescription	$5 per prescription	$15 per prescription	$15 per prescription	$15 per prescription
	Tier 2 drugs	$15 per prescription	$15 per prescription	$15 per prescription	$30 per prescription	$30 per prescription	$55 per prescription
	Tier 3 drugs	$25 per prescription	$25 per prescription	$25 per prescription	$50 per prescription	$50 per prescription	$75 per prescription
	Tier 4 drugs	20% up to $250 per prescription	20% up to $250 per prescription	20% up to $250 per prescription	20% up to $250 per prescription	20% up to $250 per prescription	20% up to $250 per prescription
Chiropractic[3] (up to 15 visits per member per calendar year)		$15 per visit	$15 per visit	$15 per visit	$15 per visit	$15 per visit	$15 per visit
Acupuncture Services (office location)		$15 per visit	$15 per visit	$15 per visit	$15 per visit	$15 per visit	$15 per visit
Teladoc		$5 copay	$5 copay	$5 copay	$5 copay	$5 copay	$5 copay

See endnotes on page 38.

Note: The information above is only a summary. For full 2018 benefit details, please refer to the 2018 Summary of Benefits.

Effective January 1, 2018. Please check the *Evidence of Coverage* (EOC) for a complete description of benefits, exclusions, limitations, and conditions of coverage of the plans. Please note that the Trio ACO HMO Network is subject to change. Please visit **blueshieldca.com/ACO** for the most current listing of providers in the network.

Off-exchange PPO plans

(PPO network available in all 58 counties)

PPO plans notated with an † are available on both the Full PPO Network and Tandem PPO Network. Groups may now offer plans from both networks.

#1 PPO plan provider for small businesses in California*

PP: Participating providers (per individual/per family)[5]

Non-PP: Non-participating providers (per individual/per family)[5]

Benefits			PLATINUM	
			Platinum PPO 0/10 OffEx*	Platinum PPO 250/15 OffEx
Calendar-year medical deductible (Copayments for covered services from participating providers accrue to both the participating and non-participating provider calendar-year medical deductibles.)		PP	$0 per individual/ $0 per family	$250 per individual/ $500 per family
		Non-PP	$0 per individual/ $0 per family	$500 per individual/ $1,000 per family
Calendar-year out-of-pocket maximum (Includes the medical plan deductible. Copayments for covered services from participating providers accrue to both the participating and non-participating provider calendar-year out-of-pocket maximums.)		PP	$3,300 per individual/ $6,600 per family	$3,600 per individual/ $7,200 per family
		Non-PP	$5,000 per individual/ $10,000 per family	$8,000 per individual/ $16,000 per family
Office visit – primary care doctor		PP	$10 per visit	$15 per visit (not subject to the calendar-year medical deductible)
		Non-PP	40%	40%
Preventive health benefits		PP	No charge[1,3]	No charge[1,3]
		Non-PP	Not covered	Not covered
Inpatient hospitalization[6] (Coinsurance percentage of up to $2,000/ day + excess charges over $2,000/day for non-participating providers)		PP	10%	10% (after deductible)
		Non-PP	40%	40% (after deductible)
Emergency room services not resulting in admission		PP	$100 per visit + 10%	$100 per visit + 10% (after deductible)
		Non-PP	$100 per visit + 10%	$100 per visit + 10% (after deductible)
Prenatal and preconception physician office visits		PP	No charge	No charge (initial visit not subject to the calendar-year medical deductible)
		Non-PP	40%	40% (after deductible)
Calendar-year pharmacy deductible (Separate from the calendar-year medical deductible. Accrues for the calendar-year out-of-pocket maximum.)		PP	None	None
		Non-PP	Not covered	Not covered
Retail prescriptions[2] (up to a 30-day supply)	**Tier 1 drugs**	PP	$5 per prescription[8]	$5 per prescription[8]
		Non-PP	Not covered	Not covered
	Tier 2 drugs	PP	$30 per prescription[8]	$30 per prescription[8]
		Non-PP	Not covered	Not covered
	Tier 3 drugs	PP	$50 per prescription[8]	$50 per prescription[8]
		Non-PP	Not covered	Not covered
	Tier 4 drugs	PP	30% up to $250 per prescription	30% up to $250 per prescription
		Non-PP	Not covered	Not covered
Chiropractic[1,4,7] Up to 12 visits per member per calendar year		PP	50%[4]	50%[4] (not subject to the calendar-year medical deductible)
		Non-PP		
Acupuncture by a licensed acupuncturist		PP	$25 per visit	$25 per visit
		Non-PP	40%	40% (after deductible)
Teladoc		PP	$5 copay	$5 copay
		Non-PP	Not covered	Not covered

See endnotes on page 38.

† Based on PPO membership. Source: CDI and DMHC Covered Lives data, 12/31/15.

Continued

Off-exchange PPO plans (continued)

(PPO network available in all 58 counties)

PP: Participating providers (per individual/per family)[5]
Non-PP: Non-participating providers (per individual/per family)[5]

Benefits		GOLD			GOLD
		Gold PPO 0/20 OffEx	**Gold PPO 450/30 OffEx**	**Gold PPO 750/30 OffEx***	**Gold PPO 1200/35 OffEx**
Calendar-year medical deductible (Copayments for covered services from participating providers accrue to both the participating and non-participating provider calendar-year medical deductibles.)	**PP**	$0 per individual/ $0 per family	$450 per individual/ $900 per family	$750 per individual/ $1,500 per family	$1,200 per individual/ $2,400 per family
	Non-PP	$0 per individual/ $0 per family	$900 per individual/ $1,800 per family	$1,500 per individual/ $3,000 per family	$2,400 per individual/ $4,800 per family
Calendar-year out-of-pocket maximum (Includes the medical plan deductible. Copayments for covered services from participating providers accrue to both the participating and non-participating provider calendar-year out-of-pocket maximums.)	**PP**	$6,800 per individual/ $13,600 per family	$7,000 per individual/ $14,000 per family	$7,000 per individual/ $14,000 per family	$7,000 per individual/ $14,000 per family
	Non-PP	$10,000 per individual/ $20,000 per family	$10,000 per individual/ $20,000 per family	$10,000 per individual/ $20,000 per family	$10,000 per individual/ $20,000 per family
Office visit – primary care doctor	**PP**	$20 per visit	$30 per visit (not subject to the calendar-year medical deductible)	$30 per visit (not subject to the calendar-year medical deductible)	$35 per visit (not subject to the calendar-year medical deductible)
	Non-PP	40%	40% (after deductible)	40% (after deductible)	40% (after deductible)
Preventive health benefits	**PP**	No charge[1,3]	No charge[1,3]	No charge[1,3]	No charge[1,3]
	Non-PP	Not covered	Not covered	Not covered	Not covered
Inpatient hospitalization[6] (Coinsurance percentage of up to $2,000/day + excess charges over $2,000/day for non-participating providers)	**PP**	30%	20% (after deductible)	20% (after deductible)	20% (after deductible)
	Non-PP	40%	40% (after deductible)	40% (after deductible)	40% (after deductible)
Emergency room services not resulting in admission	**PP**	$250 per visit + 30%	$200/visit + 20%, (after deductible)	$100 per visit + 20% (after deductible)	$100 per visit + 20% (after deductible)
	Non-PP	$250 per visit + 30%	$200/visit + 20%, (after deductible)	$100 per visit + 20% (after deductible)	$100 per visit + 20% (after deductible)
Prenatal and preconception physician office visits	**PP**	No charge	No charge (initial visit not subject to the calendar-year medical deductible)	No charge (initial visit not subject to the calendar-year medical deductible)	No charge (initial visit not subject to the calendar-year medical deductible)
	Non-PP	40%	40% (after deductible)	40% (after deductible)	40% (after deductible)
Calendar-year pharmacy deductible (Separate from the calendar-year medical deductible. Accrues for the calendar-year out-of-pocket maximum.)	**PP**	None	None	$200 per individual/ $400 per family	$500 per individual/ $1,000 per family
	Non-PP	Not covered	Not covered	Not covered	Not covered
Retail prescriptions[2] (up to a 30-day supply) — **Tier 1 drugs**	**PP**	$15 per prescription[8]	$15 per prescription[8]	$10 per prescription[8]	$5 per prescription[8]
	Non-PP	Not covered	Not covered	Not covered	Not covered
Tier 2 drugs	**PP**	$40 per prescription[8]	$40 per prescription[8]	$30 per prescription[8]	$30 per prescription[8]
	Non-PP	Not covered	Not covered	Not covered	Not covered
Tier 3 drugs	**PP**	$60 per prescription[8]	$60 per prescription[8]	$50 per prescription[8]	$50 per prescription[8]
	Non-PP	Not covered	Not covered	Not covered	Not covered
Tier 4 drugs	**PP**	30% up to $250 per prescription	30% up to $250 per prescription	30% up to $250 per prescription	30% up to $250 per prescription
	Non-PP	Not covered	Not covered	Not covered	Not covered
Chiropractic[1,4,7] Up to 12 visits per member per calendar year	**PP**	50%[4]	50%[4] (not subject to the calendar-year medical deductible)	50%[4] (not subject to the calendar-year medical deductible)	50%[4] (not subject to the calendar-year medical deductible)
	Non-PP				
Acupuncture by a licensed acupuncturist	**PP**	$25 per visit (after deductible)	$25 per visit (after deductible)	$25 per visit (after deductible)	$25 per visit (after deductible)
	Non-PP	40%	40% (after deductible)	40% (after deductible)	40% (after deductible)
Teladoc	**PP**	$5 copay	$5 copay	$5 copay	$5 copay
	Non-PP	Not covered	Not covered	Not covered	Not covered

See endnotes on page 38.

Off-exchange PPO plans (continued)

(PPO network available in all 58 counties)

Benefits			SILVER		BRONZE	
			Silver PPO 2000/45 OffEx*	Silver PPO 1700/55 OffEx*	Bronze PPO 3750/65 OffEx*	Bronze PPO 5700/60 OffEx
Calendar-year medical deductible (Copayments for covered services from participating providers accrue to both the participating and non-participating provider calendar-year medical deductibles.)		PP	$2,000 per individual/ $4,000 per family	$1,700 per individual/ $3,400 per family	$3,750 per individual/ $7,500 per family	$5,700 per individual/ $11,400 per family
		Non-PP	$4,000 per individual/ $8,000 per family	$3,400 per individual/ $6,800 per family	$7,500 per individual/ $15,000 per family	$5,700 per individual/ $11,400 per family
Calendar-year out-of-pocket maximum (Includes the medical plan deductible. Copayments for covered services from participating providers accrue to both the participating and non-participating provider calendar-year out-of-pocket maximums.)		PP	$7,000 per individual/ $14,000 per family	$7,000 per individual/ $14,000 per family	$6,800 per individual/ $13,600 per family	$7,000 per individual/ $14,000 per family
		Non-PP	$10,000 per individual/ $20,000 per family	$10,000 per individual/ $20,000 per family	$10,000 per individual/ $20,000 per family	$10,000 per individual/ $20,000 per family
Office visit – primary care doctor		PP	$45 per visit (not subject to the calendar-year medical deductible)	$55 per visit (not subject to the calendar-year medical deductible)	$65 per visit (subject to deductible)	$60 per visit (first 3 visits not subject to deductible, remaining visits subject to deductible)
		Non-PP	50% (after deductible)	50% (after deductible)	50% (subject to deductible)	50% (subject to deductible)
Preventive health benefits		PP	No charge[1,3]	No charge[1,3]	No charge[1,3] (not subject to the calendar-year medical deductible)	No charge[1,3] (not subject to the calendar-year medical deductible)
		Non-PP	Not covered	Not covered	Not covered	Not covered
Inpatient hospitalization[6] (Coinsurance percentage of up to $2,000/day + excess charges over $2,000/day for non-participating providers)		PP	40% (after deductible)	35% (after deductible)	25% (after deductible)	15% (after deductible)
		Non-PP	50% (after deductible)	50% (after deductible)	50% (after deductible)	50% (after deductible)
Emergency room services not resulting in admission		PP	$250 per visit + 40% (after deductible)	$250 per visit + $35% (after deductible)	50% (after deductible)	$200 per visit + 15% (after deductible)
		Non-PP	$250 per visit + 40% (after deductible)	$250 per visit + $35% (after deductible)	50% (after deductible)	$200 per visit + 15% (after deductible)
Prenatal and preconception physician office visits		PP	No charge (initial visit not subject to the calendar-year medical deductible)	No charge (initial visit not subject to the calendar-year medical deductible)	No charge (initial visit not subject to the calendar-year medical deductible)	No charge (initial visit not subject to the calendar-year medical deductible)
		Non-PP	50% (after deductible)	50% (after deductible)	50% (after deductible)	50% (after deductible)
Calendar-year pharmacy deductible (Separate from the calendar-year medical deductible. Accrues for the calendar-year out-of-pocket maximum.)		PP	Integrated with medical deductible	$300 per individual/ $600 per family	$225 per individual/$450 per family	$200 per individual/$400 per family
		Non-PP	Not covered	Not covered	Not covered	Not covered
Retail prescriptions[2] (up to a 30-day supply)	**Tier 1 drugs**	PP	$15 per prescription[8]	$15 per prescription[8]	$15 per prescription[8]	$15 per prescription[8]
		Non-PP	Not covered	Not covered	Not covered	Not covered
	Tier 2 drugs	PP	$55 per prescription[8]	$50 per prescription[8]	$50 per prescription[8]	$50 per prescription[8]
		Non-PP	Not covered	Not covered	Not covered	Not covered
	Tier 3 drugs	PP	$75 per prescription[8]	$75 per prescription[8]	$75 per prescription[8]	$75 per prescription[8]
		NNP	Not covered	Not covered	Not covered	Not covered
	Tier 4 drugs	PP	30% up to $250 per prescription	30% up to $250 per prescription	30% up to $500 per prescription	30% up to $500 per prescription
		Non-PP	Not covered	Not covered	Not covered	Not covered
Chiropractic[1,4,7] Up to 12 visits per member per calendar year		PP	50%[4] (not subject to the calendar-year medical deductible)	50%[4] (not subject to the calendar-year medical deductible)	50%[4] (not subject to the calendar-year medical deductible)	50%[4] (not subject to the calendar-year medical deductible)
		Non-PP				
Acupuncture by a licensed acupuncturist		PP	$25 per visit (after deductible)	$25 per visit (after deductible)	$25 per visit (after deductible)	$25 per visit (after deductible)
		Non-PP	50% (after deductible)	50% (after deductible)	50% (after deductible)	50% (after deductible)
Teladoc		PP	$5 copay	$5 copay	$5 copay	$5 copay
		Non-PP	Not covered	Not covered	Not covered	Not covered

 See endnotes on page 38.

Off-exchange PPO Savings plans

By selecting HealthEquity as your HSA administrator, you no longer have to find your own third-party HSA administrator.

HSA-compatible HDHPs*

Many small businesses opt for high-deductible PPO plan coverage for their employees. Deductibles are higher, but monthly rates are lower, and the plans come with an option of opening a health savings account (HSA) to help pay for qualified medical expenses.

Match your HSA-compatible plan with HealthEquity

Customers may now offer HealthEquity as the administrator for all of our HSA-compatible plans:

- Silver Full PPO Savings 2000/20% OffEx
- Bronze Full PPO Savings 4300/40% OffEx
- Bronze Full PPO Savings 6550 OffEx

Choosing HealthEquity is an exciting option. Blue Shield will share eligibility and claims data with HealthEquity for a seamless process.

Choose HealthEquity administration by checking the respective box on the Master Group Application when newly enrolling, or on the Request for Contract Change when renewing coverage.

Enrollment is automatic for enrolled employees. They will receive HealthEquity cards directly and will have single sign-on access from Blue Shield's member site to HealthEquity's site.

HealthEquity will bill groups directly for their monthly administration fee.

What is HealthEquity?

HealthEquity is one of the nation's oldest and largest dedicated health savings custodians. It helps individuals and families build health savings, and employers spend less on benefits through innovative integrated healthcare account administration and investment platforms backed by 24/7/365 service, personalized savings strategies, and consumer education.

* Although most consumers who enroll in an HDHP are eligible to open an HSA, members should consult with a financial adviser to determine if an HSA/HDHP is a good financial fit for them. Blue Shield does not offer tax advice or HSAs. HSAs are offered through financial institutions. For more information about HSAs, eligibility and the law's current provisions, consumers should ask their financial or tax adviser. HSA plan features may vary by institution and may be subject to change by those institutions.

Small Business HSA-compatible HDHP Full PPO plans

(Full PPO Network available in all 58 counties)

Benefits		SILVER	BRONZE	
		Silver PPO Savings 2000/20% OffEx	Bronze PPO Savings 4300/40% OffEx	Bronze Full PPO Savings 6550 OffEx
Calendar-year integrated medical and pharmacy deductible (The integrated deductible applies to both medical and pharmacy services. For family coverage, there is a separate individual deductible within the family deductible. This means that the deductible will be met for a family member when he/she meets the individual deductible or two or more family members meet the family deductible, whichever occurs first. Deductibles for participating and non-participating providers accrue separately.)	**Participating providers** (per individual/per family)[4]	$2,000 per individual on an individual plan ($2,600 per individual on a family plan)/ $4,000 per family (embedded)	$4,300 per individual/ $8,600 per family (embedded)	$6,550 per individual/ $13,100 per family (embedded)
	Non-participating providers (per individual/per family)[4]	$4,000 per individual/ $8,000 per family (embedded)	$8,600 per individual/ $17,200 per family (embedded)	$6,550 per individual/ $13,100 per family (embedded)
Calendar-year out-of-pocket maximum (Includes the calendar-year medical and pharmacy deductible, physician office dollar copays and prescription drug copays. For family coverage, there is an individual out-of-pocket maximum within the family out-of-pocket maximum. This means that the out-of-pocket maximum will be met for an individual who meets the individual out-of-pocket maximum prior to the family meeting the family out-of-pocket maximum. Calendar-year out-of-pocket maximum accumulates separately for participating and non-participating providers.)	**Participating providers** (per individual/per family)[4]	$5,550 per individual/ $6,500 per family (embedded)	$6,550 per individual/ $13,100 per family (embedded)	$6,550 per individual/ $13,100 per family (embedded)
	Non-participating providers (per individual/per family)[4]	$10,000 per individual/ $20,000 per family (embedded)	$10,000 per family/ $20,000 per family (embedded)	$10,000 per individual/ $20,000 per family (embedded)
Office visit – primary care doctor	**Participating providers** (per individual/per family)[4]	20% (after deductible)	40% (after deductible)	100% (after deductible)
	Non-participating providers (per individual/per family)[4]	50% (after deductible)	50% (after deductible)	50% (after deductible)
Preventive health benefits	**Participating providers** (per individual/per family)[4]	No charge[4]	No charge[4]	No charge[4]
	Non-participating providers (per individual/per family)[4]	Not covered	Not covered	Not covered
Inpatient hospitalization[5] (Coinsurance percentage of up to $2,000/day + excess charges over $2,000/day for non-participating providers)	**Participating providers** (per individual/per family)[4]	20% (after deductible)	40% (after deductible)	100% (after deductible)
	Non-participating providers (per individual/per family)[4]	50% (after deductible)	50% (after deductible)	50% (after deductible)
Emergency room services not resulting in admission	**Participating providers** (per individual/per family)[4]	$150 per visit + 20% (after deductible)	$250 per visit + 40% (after deductible)	$0 (after deductible)
	Non-participating providers (per individual/per family)[4]	$150 per visit + 20% (after deductible)	$250 per visit + 40% (after deductible)	$200 per visit + 40% (after deductible)
Prenatal and preconception physician office visits	**Participating providers** (per individual/per family)[4]	No charge – first visit only (not subject to the calendar-year medical deductible)	No charge – first visit only (not subject to the calendar-year medical deductible)	No charge – first visit only (not subject to the calendar-year medical deductible)
	Non-participating providers (per individual/per family)[4]	50% (after deductible)	50% (after deductible)	50% (after deductible)
Retail prescriptions[2] (up to a 30-day supply) – **Tier 1 drugs**	**Participating providers** (per individual/per family)[4]	$15 per prescription[7]	40% up to $500 per prescription[7]	$0 (after deductible)
	Non-participating providers (per individual/per family)[4]	Not covered	Not covered	Not covered
Retail prescriptions[2] (up to a 30-day supply) – **Tier 2 drugs**	**Participating providers** (per individual/per family)[4]	$50 per prescription[7]	40% up to $500 per prescription[7]	$0 (after deductible)
	Non-participating providers (per individual/per family)[4]	Not covered	Not covered	Not covered
Retail prescriptions[2] (up to a 30-day supply) – **Tier 3 drugs**	**Participating providers** (per individual/per family)[4]	$75 per prescription[7]	40% up to $500 per prescription[7]	$0 (after deductible)
	Non-participating providers (per individual/per family)[4]	Not covered	Not covered	Not covered
Retail prescriptions[2] (up to a 30-day supply) – **Tier 4 drugs**	**Participating providers** (per individual/per family)[4]	30% up to $250 per prescription	40% up to $500 per prescription[7]	$0 (after deductible)
	Non-participating providers (per individual/per family)[4]	Not covered	Not covered	Not covered
Chiropractic (Up to 12 visits per member per calendar year)	**Participating providers** (per individual/per family)[4]	Not covered	Not covered	$0 (after deductible)
	Non-participating providers (per individual/per family)[4]	Not covered	Not covered	Not covered
Acupuncture by a licensed acupuncturist	**Participating providers** (per individual/per family)[4]	$25 per visit (after deductible)	$25 per visit (after deductible)	$0 (after deductible)
	Non-participating providers (per individual/per family)[4]	50% (after deductible)	50% (after deductible)	50% (after deductible)
Teladoc	**Participating providers** (per individual/per family)[4]	$40 consult ($5 after deducitble)	$40 consult ($5 after deducitble)	$40 consult ($0 after deducitble)
	Non-participating providers (per individual/per family)[4]	Not covered	Not covered	Not covered

See endnotes on page 38.

Mirror Package for Small Business

Our plan names align closely with those in Covered California for Small Business. The names make it easy to understand the benefits each plan offers.

The plan names follow this format:

Metal tier + actuarial value + product type + network + suffix (mirror)

The **Blue Shield of California Mirror Package** offers the opportunity to purchase the same plans that Blue Shield is offering through Covered California for Small Business directly through your broker.

Please note that plans in the Mirror Package cannot be offered in conjunction with plans in any of our other small business plan packages. To learn more about the health insurance marketplace, visit **HealthCare.gov** or call **(800) 318-2596** [**TTY: (855) 889-4325**].

Blue Shield of California Mirror Package for Small Business (seven plans to choose from)

PPO	HMO
Blue Shield Platinum 90 PPO 0/15	Blue Shield Platinum 90 HMO 0/15
Blue Shield Gold 80 PPO 0/25	Blue Shield Gold 80 HMO 0/25
Blue Shield Silver 70 PPO 2000/45	Blue Shield Silver 70 HMO 2000/45
Blue Shield Bronze 60 PPO 6300/75	

Note: These plans are available for purchase directly through Blue Shield.

Our mirror PPO plans are available at all metal levels and use the same PPO network as our off-exchange PPO plans.

Trio HMO plans

Mirror HMO plans are offered on the Trio ACO HMO Network. Subscribers must work or reside in a Trio network service area to select a mirror HMO plan. Just like our off-exchange Trio HMO plans, the mirror Trio HMO plans are available in 24 counties offering comprehensive, high-quality coverage at a more affordable rate.

HMO mirror plans

Benefits		Platinum 90 HMO 0/15	Gold 80 HMO 0/25	Silver 70 HMO 2000/45
Calendar-year medical deductible – individual/family		$0	$0	$2,000/$4,000
Calendar-year out-of-pocket maximum – individual/family		$3,350/$6,700	$6,000/$12,000	$7,000/$14,000
Office visit – primary care		$15	$25	$45
Urgent care visit		$15	$25	$45
Preventive health benefits		No charge	No charge	No charge
Inpatient hospitalization		$250 per day up to five days per admission	$600 per day up to five days per admission	20% (subject to deductible)
Emergency room services		$150	$325	$350
Prenatal and preconception physician office visits		No charge	No charge	No charge
Calendar-year pharmacy deductible		None	None	$250/$500
Retail prescriptions (up to a 30-day supply)	**Tier 1 drugs**	$5[1,4,5]	$15[1,4,5]	$15[1,4,5]
	Tier 2 drugs	$15[1,4,5]	$55[1,4,5]	$55 (subject to Rx deductible)[1,4,5]
	Tier 3 drugs	$25[1,4,5]	$75[1,4,5]	$85 (subject to Rx deductible)[1,4,5]
	Tier 4 drugs	10% up to a max of $250[1,4,5]	20% up to a max of $250[1,4,5]	20% up to a max of $250 (subject to Rx deductible)[1,4,5]
Chiropractic		Not covered	Not covered	Not covered
Acupuncture		$15	$30	$45
Teladoc		$5	$5	$5

See endnotes on page 38.

PPO mirror plans with the Full PPO Network

Benefits			Platinum 90 PPO 0/15	Gold 80 PPO 0/25
Calendar-year medical deductible – individual/family (Copayments for covered services from participating providers accrue to both the participating and non-participating provider calendar-year medical deductibles.)		**Participating providers** (per individual/per family)[4]	$0	$0
		Non-participating providers (per individual/per family)[4]	$0	$0
Calendar-year out-of-pocket maximum – individual/family (Includes the medical plan deductible. Copayments for covered services from participating providers accrue to both the participating and non-participating provider calendar-year out-of-pocket maximums.)		**Participating providers** (per individual/per family)[4]	$3,350/$6,700	$6,000/$12,000
		Non-participating providers (per individual/per family)[4]	$8,000/$16,000	$10,000/$20,000
Office visit – primary care		**Participating providers** (per individual/per family)[4]	$15	$25
		Non-participating providers (per individual/per family)[4]	50%	50%
Urgent Care		**Participating providers** (per individual/per family)[4]	$15	$25
		Non-participating providers (per individual/per family)[4]	50%	50%
Preventive health benefits		**Participating providers** (per individual/per family)[4]	No charge[3]	No charge[3]
		Non-participating providers (per individual/per family)[4]	Not covered	Not covered
Inpatient hospitalization (up to $2,000/day + excess charges over $2,000/day for non-participating providers.)		**Participating providers** (per individual/per family)[4]	10%	20%
		Non-participating providers (per individual/per family)[4]	50%	50%
Emergency room services		**Participating providers** (per individual/per family)[4]	$150	$325
		Non-participating providers (per individual/per family)[4]	$150	$325
Prenatal and preconception physician office visits		**Participating providers** (per individual/per family)[4]	No charge	No charge
		Non-participating providers (per individual/per family)[4]	50%	50%
Calendar-year pharmacy deductible		**Participating providers** (per individual/per family)[4]	$0	$0
		Non-participating providers (per individual/per family)[4]	Not covered	Not covered
Retail prescriptions[1,4,5] (up to a 30-day supply)	**Tier 1 drugs**	**Participating pharmacy** (per individual/per family)[4]	$5[2,7]	$15[2,7]
		Non-participating pharmacy (per individual/per family)[4]	Not covered	Not covered
	Tier 2 drugs	**Participating pharmacy** (per individual/per family)[4]	$15[2,7]	$55[2,7]
		Non-participating pharmacy (per individual/per family)[4]	Not covered	Not covered
	Tier 3 drugs	**Participating providers** (per individual/per family)[4]	$25[2,7]	$75[2,7]
		Non-participating providers (per individual/per family)[4]	Not covered	Not covered
	Tier 4 drugs	**Participating pharmacy** (per individual/per family)[4]	10% up to $250 max[2,7]	20% up to $250 max[2,7]
		Non-participating pharmacy (per individual/per family)[4]	Not covered	Not covered
Chiropractic		**Participating providers** (per individual/per family)[4]	Not covered	Not covered
		Non-participating providers (per individual/per family)[4]	Not covered	Not covered
Acupuncture		**Participating providers** (per individual/per family)[4]	$15	$30
		Non-participating providers (per individual/per family)[4]	50%	50%
Teladoc		**Participating providers** (per individual/per family)[4]	$5	$5
		Non-participating providers (per individual/per family)[4]	Not covered	Not covered

See endnotes on page 38.

PPO mirror plans with the Full PPO Network (continued)

Benefits			Silver 70 PPO 2000/45	Bronze 60 PPO 6300/75
Calendar-year medical deductible – individual/family (Copayments for covered services from participating providers accrue to both the participating and non-participating provider calendar-year medical deductibles.)		**Participating providers** (per individual/per family)[4]	$2,000/$4,000	$6,300/$12,600
		Non-participating providers (per individual/per family)[4]	$4,000/$8,000	$6,300/$12,600
Calendar-year out-of-pocket maximum – individual/family (Includes the medical plan deductible. Copayments for covered services from participating providers accrue to both the participating and non-participating provider calendar-year out-of-pocket maximums.)		**Participating providers** (per individual/per family)[4]	$7,000/$14,000	$7,000/$14,000
		Non-participating providers (per individual/per family)[4]	$10,000/$20,000	$10,000/$20,000
Office visit – primary care		**Participating providers** (per individual/per family)[4]	$45	$75 (first three visits not subject to the calendar-year medical deductible)
		Non-participating providers (per individual/per family)[4]	50% (subject to deductible)	50% (subject to deductible)
Urgent Care		**Participating providers** (per individual/per family)[4]	$45	$75 (first three visits not subject to the calendar-year medical deductible)
		Non-participating providers (per individual/per family)[4]	50% (subject to deductible)	Not covered
Preventive health benefits		**Participating providers** (per individual/per family)[4]	No charge[3]	No charge[3]
		Non-participating providers (per individual/per family)[4]	Not covered	Not covered
Inpatient hospitalization (up to $2,000/day + excess charges over $2,000/day for non-participating providers.)		**Participating providers** (per individual/per family)[4]	20% (subject to deductible)	100% (subject to deductible)
		Non-participating providers (per individual/per family)[4]	50% (subject to deductible)	50% (subject to deductible)
Emergency room services		**Participating providers** (per individual/per family)[4]	$350	100% (subject to deductible)
		Non-participating providers (per individual/per family)[4]	$350	100% (subject to deductible)
Prenatal and preconception physician office visits		**Participating providers** (per individual/per family)[4]	No charge	No charge
		Non-participating providers (per individual/per family)[4]	50% (subject to deductible)	50% (subject to deductible)
Calendar-year pharmacy deductible		**Participating providers** (per individual/per family)[4]	$250/$500	$500/$1,000
		Non-participating providers (per individual/per family)[4]	Not covered	Not covered
Retail prescriptions[1,4,5] (up to a 30-day supply)	**Tier 1 drugs**	**Participating pharmacy** (per individual/per family)[4]	$15[2,7]	100% up to $500 max (subject to Rx deductible)[2,6]
		Non-participating pharmacy (per individual/per family)[4]	Not covered	Not covered
	Tier 2 drugs	**Participating pharmacy** (per individual/per family)[4]	$55 (subject to Rx deductible)[2,7]	100% up to $500 max (subject to Rx deductible)[2,6]
		Non-participating pharmacy (per individual/per family)[4]	Not covered	Not covered
	Tier 3 drugs	**Participating providers** (per individual/per family)[4]	$85 (subject to Rx deductible)[2,7]	100% up to $500 max (subject to Rx deductible)[2,6]
		Non-participating providers (per individual/per family)[4]	Not covered	Not covered
	Tier 4 drugs	**Participating pharmacy** (per individual/per family)[4]	20% up to $250 max (subject to Rx deductible)[2,7]	100% up to $500 max (subject to Rx deductible)[2,6]
		Non-participating pharmacy (per individual/per family)[4]	Not covered	Not covered
Chiropractic		**Participating providers** (per individual/per family)[4]	Not covered	Not covered
		Non-participating providers (per individual/per family)[4]	Not covered	Not covered
Acupuncture		**Participating providers** (per individual/per family)[4]	$45	$75 (first three visits not subject to the calendar-year medical deductible)
		Non-participating providers (per individual/per family)[4]	50% (subject to deductible)	50% (subject to deductible)
Teladoc		**Participating providers** (per individual/per family)[4]	$5	$5 (first three visits not subject to the calendar-year medical deductible)
		Non-participating providers (per individual/per family)[4]	Not covered	Not covered

The value of offering specialty coverage

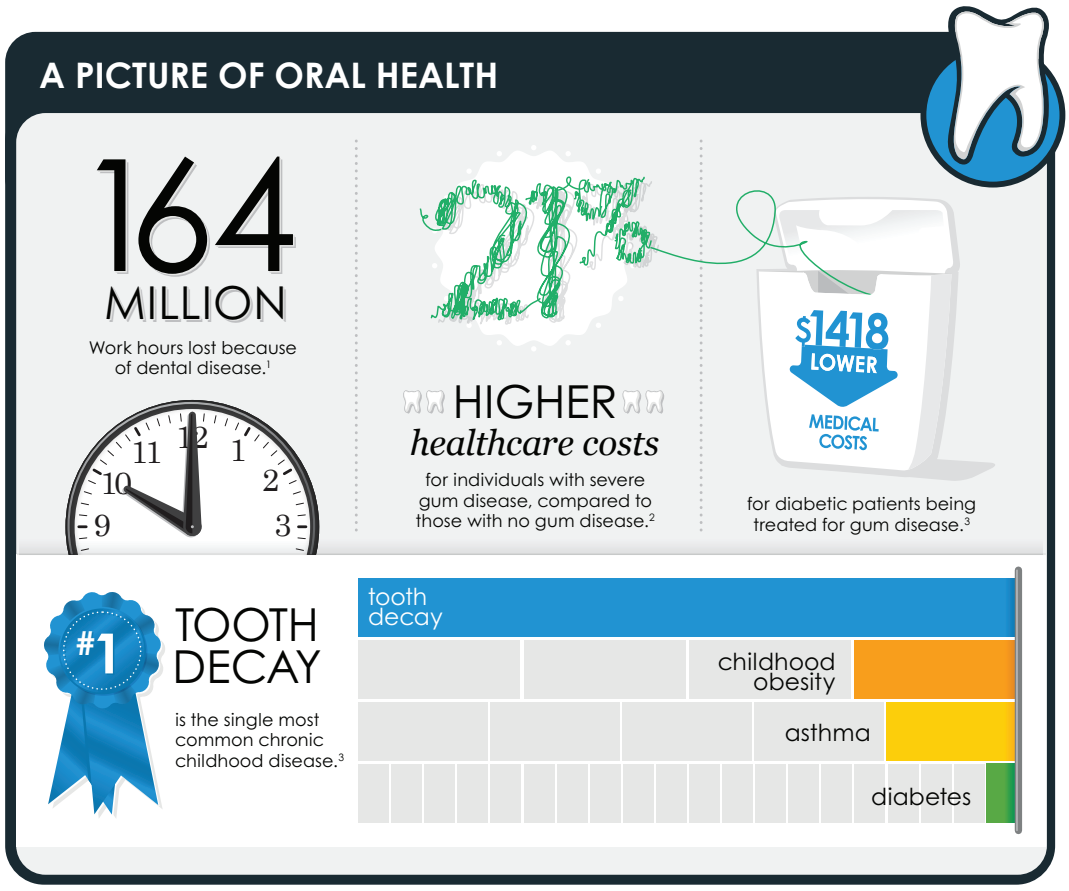
Complete your coverage with dental, vision, and life insurance

No health coverage package is complete without dental, vision, and life insurance. Groups can now take advantage of our bundling discount with 5% off dental and vision premiums when offered with a medical health plan.

With fully integrated billing and administration on all Blue Shield specialty plans, you'll be helping your employees stay happier, healthier, and more productive. All specialty plans can be purchased with or without a Blue Shield health coverage package.

Advantages worth smiling about

Broad dental provider networks and a wide range of plans make it easy to meet your company's needs.



1 Charles Bertolami, American Dental Education Association and Herman Robert Fox, Dean of the New York University College of Dentistry. Roll Call, Inc. April 23, 2009.

2 "Stress, Depression, Cortisol, and Periodontal Disease," Journal of Periodontology. November 2007.

3 Claims study. Dr. Clay Hedlund, CIGNA dental director and Dr. Marjorie Jeffcoat, Dean Emeritus and professor, University of Pennsylvania School of Dental Medicine. Presented at International Association for Dental Research. April 2009.

Blue Shield dental plans offer a variety of benefit levels, rate options, and plan flexibility. Dental coverage may help employees avoid many preventable health problems that can be harmful to their overall wellness and productivity.

- Your employees have convenient access to quality dental coverage to support their oral health. The dental PPO and In-Network Only (INO) networks include nearly 45,000 providers in California and nearly 350,000 nationwide, and the dental HMO network includes more than 26,000 providers in California.†
- Our dental plans (except voluntary plans) require a 50% employer contribution and 65% employee participation (except during promotional 25% participation periods). Voluntary dental plans don't require employer contributions.

Dental Smile Rollover Rewards program

Employees have another way to achieve savings while maintaining their health through the Dental Smile Rollover Rewards℠ program. It's automatically a part of their dental PPO plan or dental INO plan.

It's easy

All your employees need to do is visit their dentist at least once a year, and, if at the end of the year, their paid dental claims are below the claim threshold, they'll receive their rewards. And if they see a dentist in their PPO network* versus a non-network dentist, they'll receive an additional boost to their rewards amount.

The reward amount is based on the dental plan's calendar-year maximum and the program's annual claim threshold for your employee plan(s). Any rewards your employee earns will roll over in the form of calendar-year maximum funds and raise their calendar-year maximum for the next benefit year.

Here's how it works

1. Your employees visit their dentist at least once during the benefit year.
2. At the end of the benefit year, if their claims are less than their annual claim threshold, they'll earn their annual reward.
3. If all your employee claims were for network dentists, they will earn an additional $100 reward.
4. Your employees' annual reward, up to the program's reward maximum, will be added to their calendar-year maximum for the next benefit year.

The Blue Shield advantage

- Dual and Triple Options: With Dual Option, you can provide employees with a choice between any two dental plans, including voluntary plans. With Triple Option, you can offer any two dental HMO plans with a dental PPO or INO, or three dental HMO plans.
- No waiting periods so employees begin accessing care after the effective date.‡
- Reduced out-of-pocket costs when employees use a network dentist, so they pay less.

* INO plan members will automatically receive the network reward. INO plans do not cover non-network charges unless they are for emergency services. Emergency services do not count toward the reward.

† Dental providers in and out of California are available through a contracted dental plan administrator.

‡ The voluntary dental PPO and voluntary INO plans have a 12-month waiting period for "major" services. For groups with prior coverage, including "major" benefits for 12 months or more, the 12-month waiting period will be waived.

Dental PPO Smile plans

Key features:

- Plans with orthodontic coverage include a $1,000 calendar-year maximum for children and adults.
- Plans with dental implant benefits are available to all sizes of small business employers.
- Diagnostic and preventive services are covered at 100% when using network providers.
- Oral cancer screening is covered as a diagnostic and preventive service.
- You have a choice of calendar-year maximum plans up to $2,000.

Dental INO Smile plans

The Smile In-Network Only dental plan portfolio* provides a choice of options to help protect your employees' oral health and your bottom line. INO plans pay benefits on a coinsurance basis but with no non-network coverage. The INO network includes all the same providers as the dental PPO network.† The advantage of INO plans is access to a large network at reduced prices, with the same key features listed above for dental PPO plans.

An INO plan lets you tailor dental coverage for your employees by selecting options at either a $1,500 or $2,500 calendar-year maximum on a voluntary or contributory basis, and with or without orthodontia coverage.

Dental HMO plans

Dental HMO plans give your employees access to cost-effective care through the network dental provider of their choice.

Blue Shield's dental HMO plans – DHMO Basic, DHMO Plus and DHMO Deluxe – offer basic-, middle- and rich-level benefits, respectively, in addition to a voluntary option through DHMO Voluntary. Dental HMO plans are designed to help members take more control of their dental costs.†

Key features:

- No charge for covered diagnostic and preventive services, such as full-mouth X-rays, cleanings and sealants
- Orthodontic benefits for adults and children
- No waiting periods
- Virtually no claim forms
- No deductible and no calendar-year maximums
- Covered specialty-care services available with referral from a dental provider

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

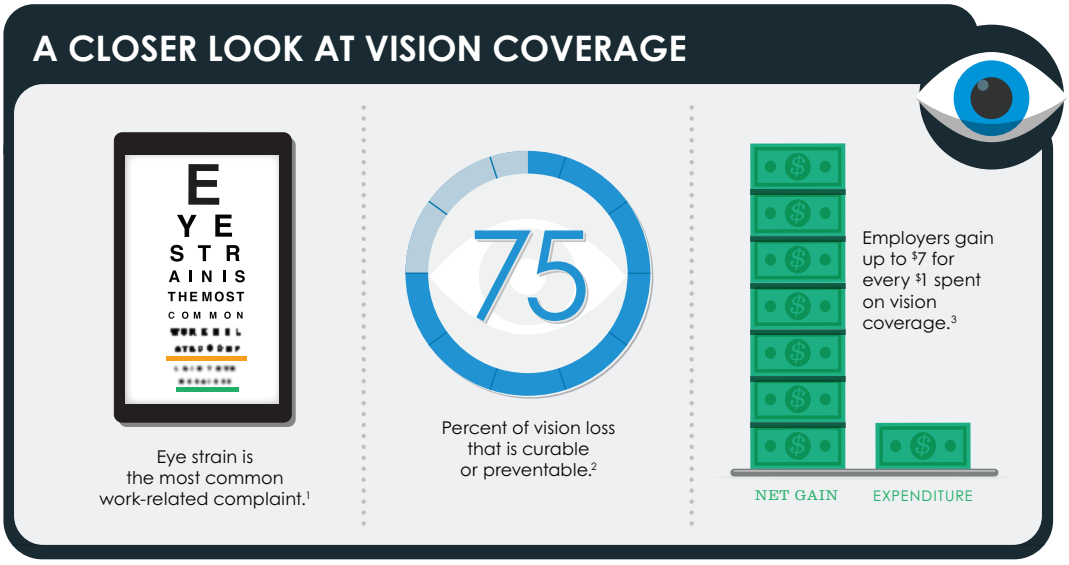
† Dental providers in and out of California are available through a contracted dental plan administrator.

Clear advantages to protect vision

With the largest vision plan provider network* in California, we make it easy for your employees to access vision care from independent eyecare professionals as well as major retail providers.

The vision network[1] includes more than 29,000 ophthalmologists, optometrists, and opticians nationwide, including more than 7,000 in California. Retail providers include LensCrafters, Site for Sore Eyes, For Eyes Optical, and Target Optical, plus wholesale locations, including Walmart, Sam's Club, and warehouse provider Costco (membership required).

Our wide range of affordable vision plans gives your employees the option to choose any vision provider they want or save money by using a network provider.



1 "Vision in Business," Vision Council of America, July 2007.
2 The Cost Utility of Eye Care and the ICO Advocacy Program, International Council on Ophthalmology, June 2008.
3 "Vision Care: Focusing on the Workplace Benefit," Vision Council of America, Fall 2008.

Easy administration

Vision plans are available with or without a Blue Shield medical plan, and vision enrollment does not need to match other Blue Shield plan enrollments.

Our small business vision plans (except voluntary plans†) require only a 25% employer contribution and 65% employee participation. Voluntary vision plans don't require employer contributions and require at least three participating employees.

There's a **two-year rate guarantee** for all new vision groups, providing added financial predictability for budgeting and planning purposes.

* Vision providers in and out of California are available through a contracted vision plan administrator.
† Voluntary plans require three or more enrolled employees.

Blue Shield advantages

Many plan choices based on frequency of benefits, copayments, allowances, and contact lens coverage option.

No waiting periods, so employees can begin accessing care after the effective date.

Online option: Our network includes a convenient online provider, MESVisionOptics.com, which allows members to shop for contact lenses, readers, and other accessories 24/7.

Rich plan options, offering $150 frame allowances with additional lens enhancements and plans that include an allowance for both glasses and contact lenses in the same benefit period.

Choosing the right vision plan is easy

What's in a name?

The plan family names – Enhanced, Preferred, and Ultimate – refer to the frequency of coverage for eye exams, lenses, and frames.

Plan family	Benefit category		
	Eye exam	Materials	Frame allowance + contact lens allowance (Plus plans)
	Frequency of benefit, every:		
Enhanced	12 months	24 months	24 months
Preferred	12 months	12 months	24 months
Ultimate	12 months	12 months	12 months

Numbers in the plan names correlate to dollar amounts for eye exam copayment, materials copayment (lenses, frames, and low-vision aids), frame allowance, and for Plus plans, additional contact lens allowance.

For example, the Preferred Vision Plus 0/25/150/120 plan offers:

- $0 eye exam copayment
- $25 for materials
- $150 frame allowance
- $120 contact lens allowance

Key features for our vision plans

- $0 or $15 copayments for eye exams.
- Plans with $150 frame allowance cover the three most common lens enhancements – progressive lenses (no-line bifocals), photochromic lenses (automatically darken in sunlight), and anti-reflective coating (reduces glare).

Protecting your family with group life insurance

Life and accidental death and dismemberment (AD&D) insurance are integral parts of a comprehensive benefits package to help employees protect their families from the financial challenges that can arise from the death or disability of a loved one.

Affordable life insurance underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life) gives your employees added security during uncertain economic times and life-changing events.

Our life insurance portfolio includes flexible plan options to offer your employees the opportunity to obtain coverage for immediate expenses, as well as longer-term obligations.

Plan design options

- Flat amount – All employees are covered at the same flat amount, e.g., $60,000.
- Multiples of salary – All employees are covered for the same multiple of salary up to a maximum amount, e.g., two times annual earnings up to the maximum benefit amount, depending on group size.
- Graded schedule – Employees are divided into classes that have different levels of benefits, e.g., executive, management, and staff levels. The benefit amount for each class must be no more than 2.5 times that of the next lower class. Each class can have its own flat amount or multiple of salary.

Active, full-time (at least 30 hours per week) permanent employees and their dependents (if optional dependent life insurance is chosen) are eligible for coverage. All employee and dependent benefits terminate at retirement.

Eligible employees	Benefit amount* (No evidence of insurability is required)	
2–9	• Minimum benefit $15,000	• Maximum benefit $30,000
10–24†	• Minimum benefit $15,000	• Maximum benefit $100,000
25–50†	• Minimum benefit $15,000	• Maximum benefit $150,000
51–100†	• Minimum benefit $15,000	• Maximum benefit $150,000 and $175,000 or $200,000

The guaranteed-issue amount is equal to the maximum benefit.

* Coverage amounts are available in plan options of $5,000 increments within the specified guaranteed-issue range based on the number of eligible employees.
† Composite rating for groups of 10 or more eligible employees.

Supplemental coverage

Infertility coverage

Blue Shield offers supplemental coverage for infertility treatment. This supplemental coverage can be purchased only with a Blue Shield of California health plan. If the group is offering multiple Blue Shield of California medical plan options to its employees, it must offer this supplemental coverage with all medical plan options. For example, if a group wishes to offer supplemental infertility coverage for its employees and currently offers one HMO and two PPO plans, the group must offer the same supplemental infertility benefit for all three plans.

Covered California for Small Business

Groups who purchase medical coverage through Covered California for Small Business and want to also offer the supplemental infertility benefit will need to purchase the mirror PPO plan with the infertility coverage directly from Blue Shield. If you are purchasing coverage through Covered California for Small Business and are interested in purchasing the PPO plan and infertility coverage, please contact your broker or Blue Shield directly.

Supplemental infertility coverage at a glance

The following procedures are limited per lifetime as shown:

- Six natural (without ovum [egg] stimulation) artificial inseminations
- Three stimulated (with ovum [egg] stimulation) artificial inseminations
- One gamete intrafallopian transfer (GIFT)
- Cryopreservation is limited to one retrieval and one year of storage
- EXCLUDED: in vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI) and zygote intrafallopian transfer (ZIFT)

Please refer to the plan contract and the *Evidence of Coverage* (EOC) for a detailed description of covered benefits, limitations and exclusions.

New group submission checklist

Please be advised that this is just a guideline and that other documentation may be required.

- ☐ Business check in amount of first month's premium **or** completed check-by-fax form for first month's premium with a copy of the voided business check drawn on the group's business account.
- ☐ Master Group Application **(please use current version – outdated versions will not be accepted)**.
- ☐ Sole proprietor, partner or corporate officer statement (Owner Affidavit) – to be completed by all eligible owners.
- ☐ Employee application **(please use current version – outdated versions will not be accepted)**.
- ☐ Refusal of Coverage form (for eligible employees declining coverage or employees declining coverage for eligible dependents).
- ☐ Prior carrier bill, including the page that lists all members on the previous policy (if applicable).
- ☐ Most recently filed DE 9C. Please reconcile to note each employee's status; if any employee is terminated, please indicate the employee's termination date.
- ☐ If there is a new hire who is not listed on the DE 9C, please provide payroll from date of hire **or** W-4 if new hire has not been working long enough to be on payroll yet.
- ☐ If owner is not on the DE 9C, please provide most recent K-1 or Schedule C (if they have filed an extension, please provide a copy of the extension and the previous year's K-1 or Schedule C).
- ☐ Fictitious Business Name Filing is required if the group uses a DBA name, or if there is more than one business name reflecting on any document or ownership paperwork submitted. Note: A Fictitious Business Name Filing is not required when the DBA appears on the business check.
- ☐ Legal documents **(see UW Guidelines)** – Articles of Incorporation, Statement of Information, Partnership Agreement, etc. that list the names of **all corporate officers/ owners/directors**.

Standalone specialty benefits

The new group submission checklist applies to dental, vision,* and life insurance* when provided alongside Blue Shield medical plans. For a simplified checklist of submission requirements when purchasing dental, vision or life insurance without a Blue Shield medical plan offering, contact your Blue Shield sales representative.

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

Helpful hints for a complete submission

Small employer medical plan eligibility:

- A small employer employs 1 to 100 employees on at least 50% of its working days during the preceding calendar quarter or calendar year.
- Since January 1, 2014, small groups with only owners (no employees) have not been eligible for small group coverage. To qualify as a small employer, the employer must employ at least one eligible W-2 "common-law employee."
- Husband-and-wife-only sole proprietor businesses are no longer eligible for small group medical coverage.

Small employer specialty* benefits-only plan eligibility:

- An owner-only small group (no employees) is eligible for dental, vision and life insurance policies when purchased without Blue Shield medical plans.
- Two eligible employees or owners are required for life coverage.
- Husband-and-wife-only sole proprietor businesses continue to be eligible for stand-alone small group specialty benefits coverage.

Frequently missed items:

- Please complete all fields on the Master Group Application. Commonly missed fields include: employer's federal tax ID number, part-time coverage question, domestic partner coverage question, employer contribution, COBRA/Cal-COBRA questions - and accurate employee counts (be sure to verify the number of enrolling employees who are declining and waiving coverage).
- Be sure all fields on the Employee Enrollment Form are completed. Commonly missed fields include: employee job title, date of hire, date of birth, number of eligible dependents and dependent information (if enrolling). Social Security numbers are required for all enrolling employees and dependents.
- Completed Refusal of Coverage forms are required for eligible dependents, including spouses/eligible domestic partners. Employees must complete a waiver for eligible dependents who are not enrolling in the plans offered.

On the check-by-fax form:

- Amount to be debited is required on the check-by-fax form. Please base this amount on the quote provided to the group for all lines of coverage selected. If you do not have a quote, please contact your small business sales team to provide a quote for you. If the final rates differ from the amount to be debited, the group will see the adjustment on its following billing statement.
- Group representative's signature is required on the check-by-fax form.

* Vision and life insurance plans are underwritten by Blue Shield of California Life & Health Insurance Company.

Endnotes

Endnotes for Off-Exchange Package PPO plans

1. Not subject to the calendar-year medical deductible.
2. If the member or physician requests a brand drug when a generic drug equivalent is available, the member is responsible for the difference in cost between the brand drug and its generic drug equivalent, in addition to the generic drug copayment. The difference in cost that the member must pay is not applied to the calendar-year medical or brand-drug deductible and is not included in the calendar-year out-of-pocket maximum responsibility calculation.
3. Preventive Health Services, including an annual preventive care or well-baby care office visit, are not subject to the calendar-year medical deductible. Other covered non-preventive services received during, or in connection with, the preventive care or well-baby care office visit are subject to the calendar-year medical deductible and applicable member copayment/coinsurance.
4. Copayments or coinsurance for covered services accrue to the calendar-year out-of-pocket maximum, except copayments or coinsurance for:
   - Charges in excess of specified benefit maximums
   - Bariatric surgery: Covered travel expenses for bariatric surgery
   - Chiropractic benefits
   - Dialysis center benefits: Dialysis services from a non-participating provider

   Copayments, coinsurance and charges for services not accruing to the member's calendar-year out-of-pocket maximum continue to be the member's responsibility after the calendar-year out-of-pocket maximum is reached. Please refer to the Summary of Benefits and *Evidence of Coverage* for additional details.
5. Member is responsible for copayment in addition to any charges above allowable amounts. The coinsurance indicated is a percentage of allowable amounts. Participating providers accept Blue Shield's allowable amount as full payment for covered services. Non-participating providers can charge more than these amounts. When members use non-participating providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar-year deductible or out-of-pocket maximum.
6. The allowable amount for non-emergency hospital services received from a non-participating hospital is $600 per day. Members are responsible for the coinsurance percentage of this $600 per day, plus all charges in excess of $600. Charges that exceed the allowable amount do not count toward the calendar-year out-of-pocket maximum.
7. Services with a day or visit limit accrue to the calendar-year day or visit limit maximum, regardless of whether the calendar-year medical deductible has been met.
8. This plan's prescription drug coverage is, on average, equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this plan's prescription drug coverage is creditable, you do not have to enroll in a Medicare Prescription Drug Plan while you maintain this coverage. However, you should be aware that if you have a subsequent break in this coverage of 63 days or more anytime after you were first eligible to enroll in a Medicare Prescription Drug Plan, you could be subject to a late enrollment penalty in addition to your Part D premium.
9. This plan's prescription drug coverage provides less coverage on average than the standard benefit set by the federal government for Medicare Part D (also called non-creditable coverage). It is important to know that, generally, you and your employees may only enroll in a Part D plan from October 15 through December 7 of each year, and if you do not enroll when first eligible, you may be subject to payment of higher Part D premiums when you enroll at a later date. For more information about drug coverage, call the Customer Service telephone number on your member ID card, Monday through Thursday from 8 a.m. to 5 p.m., or Friday from 9 a.m. to 5 p.m.

Endnotes for HSA-compatible HDHPs

1. Not subject to the calendar-year medical deductible.
2. If the member or physician requests a brand drug when a generic drug equivalent is available, the member is responsible for the difference in cost between the brand drug and its generic drug equivalent, in addition to the generic drug copayment. The difference in cost that the member must pay is not applied to the calendar-year medical or brand-drug deductible and is not included in the calendar-year out-of-pocket maximum responsibility calculation.
3. Preventive Health Services, including an annual preventive care or well-baby care office visit, are not subject to the calendar-year medical deductible. Other covered non-preventive services received during, or in connection with, the preventive care or well-baby care office visit are subject to the calendar-year medical deductible and applicable member copayment/coinsurance.
4. After the calendar-year deductible is met, the member is responsible for a copayment or coinsurance from participating providers. Participating providers accept Blue Shield's allowable amount as full payment for covered services. Non-participating providers can charge more than these amounts, for which the member is responsible, in addition to the applicable copayment or coinsurance when accessing these providers. The additional amounts can be substantial. Amounts applied to your calendar-year deductible accrue toward the out-of-pocket maximum. Charges in excess of the allowable amount do not count toward the calendar-year deductible or out-of-pocket maximum.
5. The allowable amount for non-emergency hospital services received from a non-participating hospital is $2,000 per day. Members are responsible for the coinsurance percentage of this $2,000 per day, plus all charges in excess of $2,000. Charges that exceed the allowable amount do not count toward the calendar-year out-of-pocket maximum.
6. This plan's prescription drug coverage provides less coverage on average than the standard benefit set by the federal government for Medicare Part D (also called non-creditable coverage). It is important to know that, generally, you may only enroll in a Part D plan from October 15 through December 7 of each year, and if you do not enroll when first eligible, you may be subject to payment of higher Part D premiums when you enroll at a later date. For more information about drug coverage, call the Customer Service telephone number on your member ID card, Monday through Thursday from 8 a.m. to 5 p.m., or Friday from 9 a.m. to 5 p.m.
7. This plan's prescription drug coverage is, on average, equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this plan's prescription drug coverage is creditable, you do not have to enroll in a Medicare Prescription Drug Plan while you maintain this coverage. However, you should be aware that if you have a subsequent break in this coverage of 63 days or more anytime after you were first eligible to enroll in a Medicare Prescription Drug Plan, you could be subject to a late enrollment penalty in addition to your Part D premium.

Endnotes for off-exchange and mirror HMO plans

1. If the member or physician requests a brand drug when a generic drug equivalent is available, the member is responsible for the difference in cost between the brand drug and its generic drug equivalent, in addition to the generic drug copayment. The difference in cost that the member must pay is not applied to the calendar-year medical or brand-drug deductible and is not included in the calendar-year out-of-pocket maximum responsibility calculation.
2. Subject to the calendar-year facility deductible.
3. Copayments marked with this footnote do not accrue to the calendar-year out-of-pocket maximum. Copayments and charges for services not accruing to the member's calendar-year out-of-pocket maximum continue to be the member's responsibility after the calendar-year out-of-pocket maximum is reached. Please refer to the Summary of Benefits and *Evidence of Coverage* for exact terms and conditions of coverage.
4. This plan's prescription drug coverage is, on average, equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this plan's prescription drug coverage is creditable, you do not have to enroll in a Medicare Prescription Drug Plan while you maintain this coverage. However, you should be aware that if you have a subsequent break in this coverage of 63 days or more anytime after you were first eligible to enroll in a Medicare Prescription Drug Plan, you could be subject to a late enrollment penalty in addition to your Part D premium.
5. Drugs obtained at a non-participating pharmacy are not covered, unless medically necessary for a covered emergency, including drugs for emergency contraception.

Endnotes for Mirror Package PPO plans

1. Not subject to the calendar-year medical deductible.
2. If the member or physician requests a brand drug when a generic drug equivalent is available, the member is responsible for the difference in cost between the brand drug and its generic drug equivalent, in addition to the generic drug copayment. The difference in cost that the member must pay is not applied to the calendar-year medical or brand-drug deductible and is not included in the calendar-year out-of pocket maximum responsibility calculation.
3. Preventive health services, including an annual preventive care or well-baby care office visit, are not subject to the calendar-year medical deductible. Other covered non-preventive services received during, or in connection with, the preventive care or well-baby care office visit are subject to the calendar-year medical deductible and applicable member copayment/coinsurance.
4. Member is responsible for copayment in addition to any charges above allowable amounts. The coinsurance indicated is a percentage of allowable amounts. Participating providers accept Blue Shield's allowable amount as full payment for covered services. Non-participating providers can charge more than these amounts. When members use non-participating providers, they must pay the applicable copayment, plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar-year deductible or out-of-pocket maximum.
5. The allowable amount for non-emergency hospital services received from a non-participating hospital is $2,000 per day. Members are responsible for the coinsurance percentage of this $2,000 per day, plus all charges in excess of $2,000. Charges that exceed the allowable amount do not count toward the calendar-year out-of-pocket maximum.
6. This plan's prescription drug coverage provides less coverage on average than the standard benefit set by the federal government for Medicare Part D (also called non-creditable coverage). It is important to know that, generally, you may only enroll in a Part D plan from October 15 through December 7 of each year, and if you do not enroll when first eligible, you may be subject to payment of higher Part D premiums when you enroll at a later date. For more information about drug coverage, call the Customer Service telephone number on your member ID card, Monday through Thursday from 8 a.m. to 5 p.m., or Friday from 9 a.m. to 5 p.m.
7. This plan's prescription drug coverage is, on average, equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this plan's prescription drug coverage is creditable, you do not have to enroll in a Medicare Prescription Drug Plan while you maintain this coverage. However, you should be aware that if you have a subsequent break in this coverage of 63 days or more anytime after you were first eligible to enroll in a Medicare Prescription Drug Plan, you could be subject to a late enrollment penalty in addition to your Part D premium.

Endnotes for value-added programs

1. These discount program services are not a covered benefit of the High Option Supplement plan to Medicare and Medicare PPO (with and without Rx) plans, and none of the terms or conditions of the High Option Supplement plan to Medicare and Medicare PPO (with and without Rx) plans apply.

   The networks of practitioners and facilities in the discount programs are managed by the external program administrators identified below, including any screening and credentialing of providers. Blue Shield does not review the services provided by discount program providers for medical necessity or efficacy, nor does Blue Shield make any recommendations, representations, claims or guarantees regarding the practitioners, their availability, fees, services or products.

   Discount programs are administered by or arranged through the following independent companies:

   - Alternative Care Discount Program – American Specialty Health Systems, Inc. and American Specialty Health Networks, Inc.
   - Discount Provider Network and MESVisionOptics.com – MESVision
   - Weight control – Weight Watchers North America
   - Fitness facilities – 24 Hour Fitness, ClubSport and Renaissance ClubSport
   - LASIK – Laser Eye Care of California, LLC; QualSight, Inc.; and NVISION Laser Eye Centers

   Note: No genetic information, including family medical history, is gathered, shared or used from these programs.
2. The Discount Provider Network is available throughout California. Coverage in other states may be limited. Find participating providers at **blueshieldca.com/fap**.
3. Requires a prescription from your doctor or licensed optical professional.
4. Current laws do not allow this service for members of Blue Shield Federal Employee Programs, Medicare Advantage HMO plan, or Medicare Prescription Drug Plan.

Our small business health plans are available for groups of up to 100 employees.

Regardless of what size your small business is, you'll find a large selection of plans to meet your employees' priorities. We understand no business is too small to offer coverage and that providing quality benefits is critical in attracting top talent and fueling productivity.

Thank you for selecting Blue Shield. You can count on our commitment to deliver the value and service you expect. Whether you're a business of one or 100, we want Blue Shield to be your first choice – today, tomorrow, and into the future.

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