Small Business Administrator's Guide

Effective January 1, 2017

For small businesses with
1 to 100 eligible employees

blue of california

Welcome to Blue Shield

Thank you for choosing Blue Shield of California. We are pleased to have you and your employees as part of the Blue Shield family, and we're here to support you every step of the way.

Keeping it simple

We've included simple, step-by-step instructions for eligibility, enrollment, payment and many other processes to help you easily manage your group benefits with Blue Shield. Because your time is valuable, we've organized information so you can get quick answers to your administrative questions. Just begin by referencing our Table of Contents to direct you to any specific questions you may have.

Online resources

You can visit Employer Connection at **blueshieldca.com/employer** to register for online account access. There you'll find several tools available to make administration more efficient, such as verifying eligibility details, adding coverage for a new hire or simply paying your bill. If you don't find answers to your questions in this guide or online, your broker or Blue Shield representatives are ready to help.

Thank you for choosing Blue Shield

We value your business and appreciate the opportunity to serve you, and we look forward to a long and healthy relationship.

TIP!

Employer Connection makes it easy and convenient for you to manage your group coverage online! Just visit **blueshieldca.com/ecp-getting-started**.

Note: This document is only a summary for informational purposes. It is not a contract. Please refer to the *Evidence of Coverage* or *Certificate of Insurance* and the plan contract or group policy for the exact terms and conditions of coverage. Benefits are subject to modification by Blue Shield for subsequently enacted state or federal legislation.

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For benefits administrators

Topic	Contact information
Group eligibility and online support	Group Employer Services Department **(800) 325-5166** Email: **small.group@blueshieldca.com**
Billing inquiries	Blue Shield of California Small Business Billing Services **(800) 325-5166**
Cal-COBRA eligibility, coverage, extensions and cancellations	Blue Shield of California Cal-COBRA Administration P.O. Box 629009 El Dorado Hills, CA 95762-9009 **(800) 228-9476** Fax: **(916) 350-7480**
Questions about group services for federal COBRA	**(800) 325-5166**
Questions about employer-administered flexible spending account (FSA) programs	Ceridian Benefits Services **(800) 767-4969**
For ownership or group name change	Please contact your broker or Blue Shield small group account manager and request a Name Change checklist.

For your employees

Reason	Contact information
Member assistance for benefits, claims and service providers	Blue Shield of California HMO member services at the number listed on their Blue Shield member ID card
Member assistance for Trio ACO HMO benefits and services	Blue Shield of California Shield Concierge at **(855) 664-5577** or call the number listed on their Blue Shield member ID card
Group term life insurance and accidental death and dismemberment claims inquiries	Blue Shield Life insurance claims **(888) 800-2742**
Member assistance for Blue Shield dental benefits and services	Dental member services **(888) 702-4171** 5 a.m. to 8 p.m., Monday through Friday
Member assistance for Blue Shield vision benefits and services	Vision Member Services **(877) 601-9083** 8 a.m. to 5 p.m., Monday through Friday

For your employees (continued)

Reason	Contact information
Cal-COBRA	**(800) 228-9476**
Questions about chiropractic and acupuncture benefits	American Specialty Health Plans (ASH Plans) benefits and services for HMO members: **(800) 678-9133**
Claims process and benefit information for mental health benefits and substance abuse treatments	Blue Shield mental health service administrator (MHSA) mental health benefits and substance abuse treatments For HMO and PPO members, call **(877) 263-9952** For claims, call **(877) 263-9952**
To order mail service prescriptions	Mail service pharmacy: **(866) 346-7200**
Member assistance for Blue Shield 65 Plus℠ (HMO) benefits and services	Blue Shield 65 Plus (HMO) member services **(800) 776-4466** TTY: **711**
Member assistance for Blue Shield Medicare Rx benefits and services	Blue Shield of California Medicare PDP Blue Shield of California Medicare Rx Plan (PDP) Member Services **(888) 239-6469** TTY: **711**
No-cost language services for members to reach an interpreter, have documents read aloud, or sent in the mail	Language-assistance services Call the phone number on the member ID card or **(866) 346-7198**

Online resources

Get the most from Employer Connection

Online administration is available with the click of a mouse. You'll find time- and money-saving tools that will help make benefit administration easier, making you even more efficient. Employer Connection offers you easy, 24-hour access to the information you need about Blue Shield coverage. You can easily add, update, or terminate coverage for your employees and dependents, as well as view plan benefit details and pay your bill online, anytime.

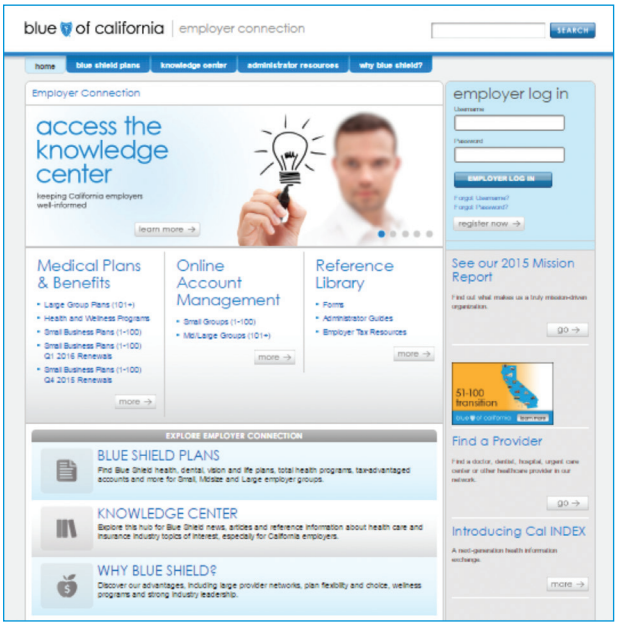
Visit Employer Connection at **blueshieldca.com/employer** anytime to find information about:

- Online account management
- Blue Shield plans and provider networks
- Health and wellness programs
- The latest Blue Shield news, and more

Manage your account online

Learn more about all the features that Employer Connection offers at **blueshieldca.com/ecp-getting-started**. Benefit administrators can register for online account access at **blueshieldca.com/employer**. Once there, you can securely log in 24/7 to:

- Manage your member roster with enrollments and terminations
- View and manage medical, dental, vision and life insurance plans in a single place
- Create and download census and billing reports
- Conduct open enrollment online, with an option for employees to self-enroll
- View your Blue Shield invoice
- Make one-time payments, or set up automatic payments
- Order Blue Shield medical ID cards
- Grant additional user access to your Employer Connection account



Copy this flier for your employees to see how to access Blue Shield information on-the-go.

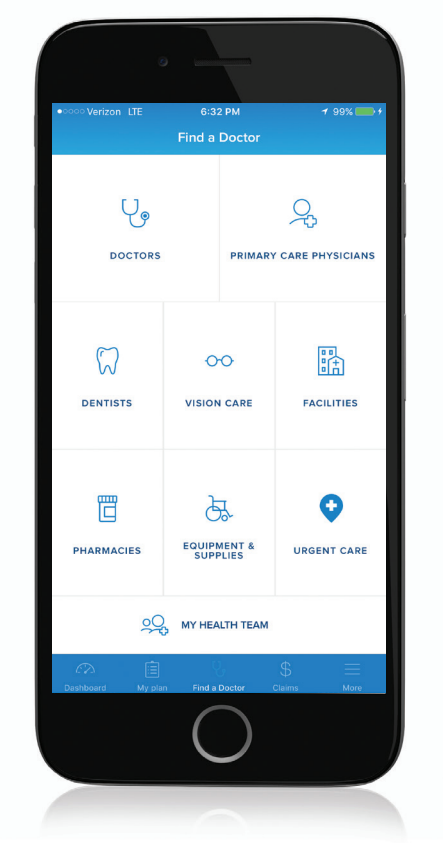
Online and mobile tools

Updated, easier and more accessible

Blue Shield members can now get even more of their health plan information anytime, anywhere. The Blue Shield mobile app and website have been designed for easier access on the go.

Download the Blue Shield of California mobile app on the App Store℠ or Google Play™.

Visit the redesigned website by entering blueshieldca.com in your mobile device's browser.



Whether you are using the mobile app or the website, each offers access to more features than ever. Features and plan details may vary depending on your specific plan type.

Features

- **View Blue Shield member ID card**
- **View deductible and copayment year-to-date totals**
- **View claims**
- **Benefits information[1]**
- **Register**
- **NurseHelp 24/7℠**
- **HSA/FSA balances linked to your HealthEquity account[2]**
- **Contact us**
- **Find a doctor or urgent care**

GET IT ON Google play

Download on the App Store

Member registration is easy

One username and password gives you 24/7 access to your health plan information from your desktop, laptop and mobile device.

Download the mobile app today or visit blueshieldca.com/mobile for more details and FAQs.

1 See your *Evidence of Coverage* (EOC) or check with your company's plan administrator for your specific benefit coverage.

2 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.

Blue Shield of California is an independent member of the Blue Shield Association A47784 (10/16)

Copy this flier for your employees to see how to access Blue Shield information on-the-go.

Get covered right down to your identity!

As an eligible* Blue Shield medical plan member, you can now get identity protection services such as identity repair assistance, identity theft insurance and credit monitoring for you and your covered family members. It makes good sense, and it's no charge.

You 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.

Online resources

For your employees

When employees come to you with questions about their health coverage, you can refer them to the Blue Shield member portal at **blueshieldca.com**. They can view their confidential health plan information securely, as well as find health and wellness, provider and pharmacy information and much more. Online registration for our website is simple, quick, and secure – employees choose a username and password, and their personal information will be encrypted to ensure their privacy. Once employees log in, they can:

Select *Member Exclusives* to:

- See coverage highlights and details of their health, dental and vision plan coverage
- Learn about their copayment and deductible amounts
- Check the status of their claims
- Print temporary Blue Shield member ID cards
- Download a copy of their Summary of Benefits and Coverage form

Select *Find a Doctor* to:

- Search for a doctor, Independent Practice Association (IPA) or medical group, hospital, urgent care center, dentist, pharmacy, vision care or alternative care practitioner
- See maps to their selected provider
- Download a personalized provider directory
- Read and write patient reviews of doctors in the directory

Select *Find a Doctor Performance Profile* to:

- Compare network providers, so they can make better healthcare choices about which provider to see
- Get easy, online access to quality scores, as well as efficiency indicators and patient satisfaction scores for HMO medical groups, individual physicians and hospitals

Select *Wellness Tools* to:

- Learn about our health management programs and apply online for some programs
- Participate in our online program and create a confidential health and fitness plan that's tailored to their individual needs
- Learn how to talk with a nurse by phone or online through our NurseHelp 24/7 program
- Use our health encyclopedia to research a condition or treatment
- Sign up for our monthly *Health Update* email newsletter filled with timely health and benefits information
- Download a copy of the Preventive Health Guidelines

Select *Drugs* to:

- Search among our network of more than 5,400 retail pharmacies in California, two specialty pharmacies, and one mail service pharmacy. Employees can use *Find a Pharmacy* to locate the network pharmacy closest to them.
- Check for drug interactions among prescription drugs, over-the-counter medications, dietary supplements and herbal products using our *Drug Interaction Checker.*
- Order up to a 90-day supply of covered maintenance medications online through our contracted mail-service vendor and have them delivered directly to the employee's home or office.

We encourage you to let your employees know to register on **blueshieldca.com**. They can find a wealth of information about their coverage and helpful wellness resources.

Health and wellness programs

Blue Shield has an array of services and support that your employees can use to meet their health goals. Requiring no administration on your part and available at no extra cost to you or your employees, these valuable resources can enhance your group's healthcare coverage. Members can use the contacts provided to utilize these resources.

Resource	Contact
NurseHelp 24/7 – This nurse support service offers your employees access to registered nurses who can provide immediate answers to medical questions and reliable information about health conditions. Your employees have the option to use the chat function or speak directly to a registered nurse on the phone.	Call **(877) 304-0504.** Or, log in to **blueshieldca.com** and click on *Be Well*, then *NurseHelp 24/7*.
Join the Wellvolution! – We know we could be healthier, but life is busy and things get in the way. Introducing Wellvolution,® a well-being solution for real people with real lives. Wellvolution is the next generation in wellness programs. Starting with **mywellvolution.com**, all Wellvolution registered members get access to the Well-Being Tracker™ platform and its fundamental components, the **Well-Being Assessment** and the **Daily Challenge**® program. These two components are a great start for helping members to improve their health one small step at a time.	Go to **www.mywellvolution.com**.
Decision support resources – When employees are faced with an important medical decision, these online resources help them determine the care that's right for them. Our decision support resources provide members with access to a comprehensive range of tools and information including health topics and conditions, symptom checker, decision points, treatment options, interactive tools, drug interactions, videos, community networking and more.	For more information, log in to **blueshieldca.com** and click on *Be Well*.
Condition Management Program – This program helps your employees manage chronic conditions that can significantly impact their physical and emotional health, such as diabetes, asthma, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD) and heart failure. They offer up-to-date health and wellness information and strategies for self-management, at no extra charge. In addition, we offer a Prenatal Program, which includes pregnancy assessments, 24/7 phone support by maternity nurses and a mailing of a popular pregnancy book as well as other helpful information on prenatal and postpartum care.	Call **(866)-954-4567.** For the Prenatal Program, call **(888) 886-4596**. Or, log in to **blueshieldca.com** and click on *Be Well*, then *Condition Management*. For the Prenatal Program, click on *Women's Health*.
Case management programs – Customized patient support helps members with highly acute or complex conditions and members with catastrophic illnesses and injuries. Registered nurses provide comprehensive, high-touch coordinated case management with the goal of improving health outcomes, quality of life and member satisfaction.	For more information about case management programs, members can call **(877) 455-6777** toll-free.
Wellness discount programs – We offer a wide range of member discount programs* that can help your employees save money and get healthier. These include Weight Watchers, 24 Hour Fitness, ClubSport and Renaissance ClubSport, Alternative Care Discount Program, Discount Vision Program and LASIK discounts.	For more information and to see a list of wellness discount vendors, members can log in to **blueshieldca.com/wellnessdiscounts**. For information on vision network providers, members can log in to **blueshieldca.com**, click on *Find a Doctor*, and then *Vision Care*.

* 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.

Some services offered through the discount program may already be included as part of the Blue Shield health plan covered benefits. Members should access those covered services prior to using the discount program.

Employees who are not satisfied with products or services received from the discount program may use the Blue Shield grievance process described in the Grievance Process section of the *Evidence of Coverage* or *Certificate of Insurance*. Blue Shield reserves the right to terminate this program at any time without notice.

Discount programs administered by or arranged through independent companies:

- Alternative Care Discount Program – American Specialty Health Systems, Inc. and American Specialty Health Networks, Inc. (ASH Networks)
- Discount Vision Program – MESVision
- LASIK – NVISION Laser Eye Centers; QualSight, Inc.
- Weight control – Weight Watchers North America
- Fitness facilities – 24 Hour Fitness, ClubSport, and Renaissance ClubSport

Note: This document is only a summary for informational purposes. It is not a contract. Please refer to the *Evidence of Coverage* or *Certificate of Insurance* and the plan contract or group policy for the exact terms and conditions of coverage. Benefits are subject to modification by Blue Shield for subsequently enacted state or federal legislation. No genetic information, including family medical history, is gathered or used for these programs and should not be provided.

Assisting your employees

Eligibility requirements

The following sections explain the basic eligibility requirements for your employees and their dependents. Eligibility limits may vary among groups, so please consult your *Evidence of Coverage/Certificate of Insurance* or Group Health Service Contract/Group Policy, or contact your Blue Shield service representative or account manager for any special provisions your company may have.

Eligible employees

Use the four employee categories described below to help determine whether an employee is eligible for group coverage.

1. Full-time employees

A full-time employee is eligible for coverage if he or she:

- Works an average of 30 hours per week as a permanent, year-round employee and is actively engaged in conducting your company's business
- Performs job duties at your company's usual place of business
- Receives wages, commissions, or a salary

Please note: Spouses and domestic partners working for the same employer group can each elect to enroll separately as employees, or one may be a dependent on the other's coverage.

2. Part-time and temporary employees

An employee working 20 to 30 hours each week on a permanent year-round basis is not eligible for group coverage unless your group contract provides benefits for all employees in this category under state law.

The part-time employees being offered healthcare coverage must have worked a minimum of 50% of the preceding calendar quarter. This is an individual eligibility requirement for each part-time employee being offered coverage under this option.

An employee working fewer than 20 hours each week on average or an individual working on a temporary or substitute basis is not eligible for group coverage.

Please note that the most recent DE9C is required when you add a part-time employee. In addition, eligibility for part-time employees can only be added during your renewal period.

3. Sole owners or partners of a partnership

An owner or partner of a partnership is eligible for coverage if he or she:

- Serves as a full-time employee
- Works an average of 30 hours per week and actively engages in conducting your company's business
- Performs the job duties at your company's usual place of business
- Qualifies as an employee under your company's health coverage plan contract

4. Rehired employees

The small group enrollment guidelines indicate that if an employee is rehired within six (6) months of cancellation of coverage, the effective date will be the date of rehire if the paperwork is received within 60 days of the rehire date. He or she:

- Completed your company's eligibility waiting period during the prior employment period, and resumed active employment within six months of loss of coverage with your company; or
- Terminated during the prior employment period to enter the armed forces, and resumed active employment within the time outlined by the law; or
- Terminated due to a disability, and resumed active work within one month after recovering from the disability.

Otherwise, the rehired individual will be considered a new employee and must complete your company's new-hire eligibility waiting period.

Please note: Re-employment notification must be indicated on the rehired individual's Employee Application.

State law defines a part-time employee as someone working at least 20 hours a week, and gives a small group employer with fewer than 50 eligible employees the option to offer coverage to part-time employees. For more information about this option for groups, contact your Blue Shield representative.

Dependent eligibility

There are five categories of dependents, each with its own eligibility requirements.

1. Spouses

An employee's legally married spouse is eligible for dependent coverage if he or she is not legally separated from the employee. Blue Shield treats same-gender spouses exactly the same as opposite-gender spouses.

2. Domestic partners

Blue Shield plans cover domestic partners under the same terms and conditions as spouses, and domestic partners follow the same enrollment procedures as spouses. Blue Shield offers two coverage options for domestic partners:

1. Narrow coverage: Both partners have registered with the state of California by filing a Declaration of Domestic Partnership. Both partners must be of the same gender, with one exception: Opposite-gender partners are allowed if one partner is at least 62 and eligible for Social Security.
2. Broad coverage: California state registration is not required, and the partners may be the same or opposite gender.

Domestic partners in both options must also meet Blue Shield's dependent eligibility requirements as contractually defined.

Please note: Blue Shield does not require a copy of the Declaration of Domestic Partnership registration filed with the state of California or any other declaration or affidavit of domestic partnership.

3. Dependent children

A child of an employee (or employee's spouse or domestic partner) by birth, legal adoption, placement for adoption, or legal guardianship is eligible for coverage if he or she is:

- Not a company employee; and
- Younger than 26 years of age regardless of student, employment, residential, or marital status.

If your company employs both parents, their children may be covered as dependents of either parent, but not both.

4. Disabled over-age dependent children

If a disabled child who is covered under your Blue Shield plan reaches the maximum age limit specified in your Group Health Service Contract/Group Policy or *Evidence of Coverage/Certificate of Insurance*, coverage may continue if the child meets both of the following criteria. He or she is:

- Incapable of self-sustaining employment because of a mentally or physically disabling injury, illness, or condition; and
- Unmarried and dependent on the employee for economic support.

The child's primary physician must submit to Blue Shield a written certification of the disability at all of the following times:

- Within 60 days of the date the dependent child reaches the age at which eligibility would otherwise cease.
- A recertification of disability may be required within two years after the initial medical certification and annually thereafter.

In addition, the employee must submit a Declaration of Disability for Over-Age Dependent Children Form.

5. Qualified medical child support order (QMCSO)

A dependent child who is ordered to have coverage by the court is eligible even if he or she is:

- Born out of wedlock, or
- Not claimed as a dependent on the parent's federal income tax return, or
- Not residing with the parent or within the Blue Shield HMO service area.

(For additional information on out-of-service area coverage, see the Away From Home Care program on page 16.)

If the parent fails to apply for coverage for a child, Blue Shield will enroll the child if a copy of the court order is presented to Blue Shield by:

- The district attorney, or
- The other parent or person having custody of the child, or
- The group contact.

Enrollment paperwork for court-ordered dependent children must be submitted as soon as possible. Include a copy of the employee's Subscriber Change Request form and a copy of their court orders.

Access to care outside of California

Two programs provide access to care for eligible employees who are traveling outside of California, and for eligible family members living out of state.

BlueCard Program

For Blue Shield HMO plan members

The BlueCard® Program provides members and their covered dependents access to medically necessary urgent and emergency care throughout the United States and worldwide. If members need emergency care services, they should seek care at the nearest medical facility and appropriately use the 911 emergency response system when it is available.

Please note: HMO members are covered only for medically necessary urgent and emergency care services outside of California.

For Blue Shield PPO plan members

BlueCard provides members and their covered dependents access to medical care throughout the United States and worldwide.

Your health plan's *Evidence of Coverage* or *Certificate of Insurance* describes member eligibility in the BlueCard Program. If your employees have questions about BlueCard, please refer them to their member guide for step-by-step instructions on how to use their BlueCard services.

Please note: Certain non-emergency healthcare services, such as hospitalization, require prior authorization from Blue Shield. Care provided by a non-network provider or a non-BlueCard provider may be subject to higher out-of-pocket costs.

The BlueCard Program provides members and their covered dependents with worldwide access to care! Here's the link: **blueshieldca.com/employer/plans/out-of-area-coverage.sp**.

Away From Home Care program (for HMO plan members)

The Away From Home Care® program provides HMO plan members and their covered dependents access to care if they are:

- Long-term travelers who travel outside California for a minimum of 90 consecutive days, but no more than 180 days, and return to their permanent residence
- A family living apart, which applies to employees required by court orders to take responsibility for their dependents' medical coverage, and the custodial parent or dependent child lives outside of California
- Students who are an employee's dependent and who attend school and live outside the HMO service area, but whose principal residence is the employee's permanent residence

If your employee resides or works in the plan service area, they are eligible for coverage as a subscriber the day following the date they complete the applicable waiting period. Their spouse or domestic partner and all their dependent children who live or work in the plan service area are eligible at the same time.

Special arrangements may be available for:

- Dependents who are full-time students
- Dependents of subscribers who are required by court order to provide coverage
- Dependents and subscribers who are long-term travelers as described above

Please note a few restrictions:

This program's benefits will not extend beyond your group contract's effective date, and program coverage is not automatic. It must be renewed annually.

To receive coverage, members or their dependents living outside of California must live in a host plan service area.

Members utilizing the program's services outside of California will receive the benefits offered by the host plan in the state they are visiting.

If you or your employees have questions about using these benefits, please contact Member Services to request an Away From Home Care program brochure. HMO plan members can also find this brochure at **blueshieldca.com** by clicking on the *My Health Plan* tab and then *Resources*.

HMO plan members must apply for Away From Home Care benefits. They can do so by calling the HMO Member Services number in the Contact Information section.

Ineligible individuals

Below are some examples of individuals who are not eligible for healthcare coverage under your Blue Shield group coverage:

- Parents, siblings, nieces, or nephews of employees, or their spouses
- Dependents living and working outside of a Blue Shield HMO plan service area who do not meet Away From Home Care program requirements
- Students living and attending school outside of Blue Shield's HMO plan service area who do not meet Away From Home Care program requirements
- Foster children and grandchildren who are not legally adopted or for whom legal guardianship has not been established

TIP!

Your employees who are ineligible for group coverage can still apply for health coverage through a Blue Shield individual and family plan. Contact your broker for more information.

Eligibility requirements at a glance

Type of enrollee	Requirements
Employee: permanent, year-round, full-time	• Works an average of 30 hours per week • Performs job duties at your company's usual place of business (W2 employees)
Employee: part-time (Small group employers have the option to offer coverage to part-time employees)	• Works 20 to 30 hours per week • The part-time employees being offered healthcare coverage must have worked a minimum of 50% of the preceding calendar quarter. This is an individual eligibility requirement for each part-time employee being offered coverage under this option.
Employee: temporary	Not eligible for Blue Shield group coverage
Sole owner or partner of a partnership	• Full-time employee and works an average of 30 hours per week • Performs job duties at your company's usual place of business • Qualifies as an employee under your company's Blue Shield Group Health Service Contract
Spouse	Legally married spouse who is not legally separated from the employee
Domestic partner	• Domestic partner who is not terminated from the domestic partnership • Domestic partners are covered under the same terms and conditions as spouses
Dependent children	Child of an employee (or employee's spouse or domestic partner) by birth, legal adoption, placement for adoption, or legal guardianship who is younger than 26 years of age, regardless of student, employment, residential, or marital status.
Disabled over-age dependent children	If a disabled child who is covered under a Blue Shield plan reaches the maximum age limit, coverage may continue if the child meets both of the following criteria. He or she is: • Incapable of self-sustaining employment because of a mentally or physically disabling injury, illness, or condition; and • Unmarried and dependent on the member for economic support.
Individuals ineligible for group coverage	If part-time and temporary employees who are not eligible for your group coverage express interest in finding a health plan, they can apply directly to Blue Shield for health coverage through an individual and family plan. Please contact your Blue Shield broker for more information. You can also give your employees a copy of the Individual and Family Plan brochure, included in your Administrator's Kit.

Enrollment procedures at a glance

Please refer to the list of forms in the Appendix. All forms are available online at **blueshieldca.com/employer**.

Enrollee	Eligibility date	When to report	Online enrollment
New employees and their dependents	The first billing date after the new employee completes your group's waiting period	Within 60 days of the employee's eligibility date – an application for subscriber enrollment is considered late if there is no Refusal of Coverage on file and it is received after 60 days from the eligibility date.	• Employee Application
Current employees transferring from one plan to another	Effective date of your group's renewal date	Open enrollment	• Log on to **blueshieldca.com/employer**
Employees or dependents who lose other group coverage	The date the employee or dependent loses the other group coverage	Within 60 days after the employee or dependent loses the other group coverage	• The individual's Refusal of Personal Coverage section of the Employee Application • Written evidence of loss of coverage from previous carrier • Employee Application • Subscriber Change Request form (for dependents only)
Rehired employees	If an employee is rehired within six (6) months of cancellation of coverage, the effective date will be the date of rehire if the paperwork is received within 60 days of the rehire date.	Within 60 days of the employee's eligibility date	• Employee Application • Employee Change Transmittal form
Spouses	• The date of marriage; or • The date they lost their other group coverage	Within 60 days after the marriage or within 60 days after the loss of their other group coverage	• Subscriber Change Request form • Written evidence of loss of coverage from previous carrier
Domestic partners	• The date of partnership; or • The date they lost their other group coverage	Within 60 days after partnership is declared or within 60 days after the loss of their other group coverage	• Subscriber Change Request form
Newborns	The date of birth*	Within 60 days of birth	• Subscriber Change Request form
Adopted dependents	The date the member or spouse or domestic partner has the right to control the child's health care	Within 60 days of the date the member or spouse or domestic partner has the right to control the child's health care	• Adoption papers or a medical authorization form, a health facility minor release form or a relinquishment form • Subscriber Change Request form
Dependents subject to a court order for medical support	The date the court order is issued (or the date specified in the court order)	Earliest possible date	• A copy of the court order • Subscriber Change Request form

* Life insurance has different guidelines for newborns. See life insurance administration section.

Note: All signed authorizations should be kept for your own records.

Enrollment procedures

We want enrollment to go smoothly for you and your employees. Here's a guide to help you easily understand the process.

Annual open enrollment

Open enrollment is a 30-day window for your employees to select their benefits. The window should be 20 working days long and conclude 10 working days prior to your group's effective renewal date of coverage.

During open enrollment:

- An employee who originally refused coverage can enroll
- An employee can add dependents that originally refused coverage
- Employees and their dependents may enroll into a Blue Shield-sponsored plan from another carrier or switch from one Blue Shield plan to another (e.g., Blue Shield HMO to Blue Shield PPO)

This is also the time when you can:

- Restructure the plan options you currently offer your employees
- Change waiting periods
- Change contribution levels/amounts
- Change domestic partner coverage to either the state-mandated coverage (same-gender only and registered with the state) or the Blue Shield version, which allows for same- and opposite-gender coverage, with no state registration required
- Request to cover employees working 20 to 30 hours a week

Waiting periods

There are four options for coverage to begin following any waiting period. Coverage for eligible employees will become effective following completion of the waiting period on the day specified.

1. Effective first of month following date of hire (If hired on the first of month, coverage will be effective first of following month)
2. Effective first of month following 30 days from date of hire
3. Effective first of month following 60 days from date of hire
4. Effective on the 91st day following date of hire

An employer may impose a bona fide, employment-based orientation (affiliation) period for new employees which cannot exceed 30 days. A waiting period may also be imposed before coverage becomes effective, beginning the first day after any orientation period and not to exceed 90 days.

Please note that if the employer imposes an orientation period when completing an enrollment form for a new employee, the "date of hire" is the first day after completion of the orientation period.

We encourage you to contact your broker or Blue Shield account manager to arrange a benefit meeting for your employees with a Blue Shield representative, who will describe the plan benefits, value-added programs and answer any questions employees may have. While these open enrollment benefit meetings are not required, many small businesses and employees find them helpful.

Conduct open enrollment online!

If your employees do not want to make a change, they do not have to do anything but simply pay their bill at the new rate.

If an employee decides to make a plan change or add or cancel dependents, make the changes online at **blueshieldca.com/employer**.

If existing employees who previously refused coverage decide to enroll in a Blue Shield plan, easily enroll them online with Employer Connection.

It's important to remind your employees that these types of changes must be submitted to Blue Shield **by the last business day of your renewal month**.

Please note: Spouses and domestic partners working for the same employer group can each elect to enroll separately as employees, or one may be a dependent on the other's coverage.

Employees who are absent during open enrollment

If you know that an employee will not be at work during the open enrollment period, we suggest that you:

- Discuss the coverage options with the employee before the open enrollment period and submit the changes online.

Initial enrollment for new employees

For new employees hired after your group's effective date:

- New employees and their dependents are eligible for coverage after completing your group's waiting period. We do not waive the waiting period for new employees, although your group's contract may designate a zero waiting period for specific job titles. You can make changes to waiting periods during open enrollment.
- Blue Shield must receive the online submission no later than 60 days after a new employee completes your group's waiting period.
- Employees and dependents who decline coverage during their initial enrollment period must waive coverage if enrolling online or complete the Refusal of Personal Coverage section of the Employee Application if submitting information in paper form. Please retain a copy of the completed Refusal of Personal Coverage section and forward the original to Blue Shield immediately.

TIP!

Visit the Employer Connection Getting Started page to learn more about conducting open enrollment online. **www.blueshieldca.com/ecp-getting-started**.

Adding dependents

To add a dependent, simply go to Employer Connection.

Please make sure that HMO plan applicants select a Personal Physician for each dependent. See page 22 for more information.

To add a newborn child, you must complete the submission online within 90 days from the child's date of birth. During the child's birth month, HMO plan members must select for the child a Personal Physician who is with the same IPA or medical group as the mother's Personal Physician (or father's Personal Physician if the mother is not covered on the plan). After 60 days, the newborn child will be considered a late enrollee. (See page 23 for more information on late enrollment.)

After the employee completes, signs and dates the Subscriber Change Request form, you may complete the process online:

1. Verify that the addition meets eligibility requirements.
2. Make sure the form is properly completed, signed and dated.
3. Give the employee a copy of the completed form.
4. When using the Eligibility Change Transmittal form, be sure to list the employee's name and Social Security number (or any other identification number).
5. Go online to **blueshieldca.com** for the Subscriber Change Request form and the Eligibility Change Transmittal form.

TIP!

Save time today – easily add dependents online at Employer Connection. Simply go to **blueshieldca.com/ecp-getting-started** to watch a demo.

Identifying plan-to-plan transfers

When your company has more than one subgroup or health plan, identify plan-to-plan transfers on either the Subscriber Change Request form or the Employee Change Transmittal form. These changes will appear on your next Group Payment Request. For example, when an employee transfers from a Blue Shield PPO plan to a Blue Shield HMO plan during open enrollment, you must submit either the Subscriber Change Request form or the Employee Change Transmittal form.

TIP!

Make sure you keep the employee signed authorizations on file for your own records.

Selecting a Personal Physician (HMO plan only)

This step determines which doctor will coordinate all healthcare needs for your employee on an HMO plan, with the exception of mental health and substance abuse services.

Your employee must select a Personal Physician who is located near his or her home or work address. Each of your employee's dependents must also choose his or her own Personal Physician.

Blue Shield will designate a Personal Physician for employees or dependents who:

- Do not select a Personal Physician when they enroll in an Access+ HMO,® a Local Access+ HMO plan or the Trio ACO HMO
- Select a doctor who is not a participating physician in the Access+ HMO, Local Access+ HMO plan or the Trio ACO HMO provider network
- Choose a specialist who is not also a Personal Physician
- Select a doctor who is not accepting new patients, unless the employee is a current patient and checks the appropriate box on the Employee Application

We will notify the member of the designated Personal Physician, which remains in effect until the member chooses a different one. Your employees can select a new Personal Physician at any time by following the step-by-step instructions in their member guide.

Please note:

If an employee who enrolls in the Trio ACO HMO, Access+ HMO or Local Access+ HMO is unable to choose a Personal Physician during the open enrollment period, we will designate one based on their ZIP code. We will notify the member of this selection, which will remain in effect until the member chooses a different Personal Physician. Members can change their Personal Physician at any time.

Late enrollment

Managing late enrollment

A late enrollee is an eligible employee or dependent who declines coverage during the initial enrollment period (the period during which an individual is eligible to enroll in a Blue Shield group plan) and then later requests enrollment.

- A late enrollee must wait until your company's next open enrollment period to obtain coverage if he or she later decides to enroll.
- Blue Shield will not consider requests for late enrollees to be added for an earlier effective date.

There are a few exceptions for employees who do not enroll during the initial enrollment period. For the following exceptions, Blue Shield will enroll these employees, along with newly acquired dependents, after the initial enrollment period:

- Following the birth of a newborn, the adoption of a child, or a qualified medical child support order (QMCSO)
- After marriage
- After the establishment of a domestic partnership
- After the loss of eligibility of other coverage

For enrollment due to the above instances, you must submit the enrollment online no later than 60 days from the event.

If an enrolled employee acquires a new dependent through birth, adoption, marriage, or establishment of a domestic partnership, and you offer more than one plan, the enrolled employee may change plans at that time and may enroll all other eligible dependents.

Exceptions to late enrollment

An employee applying for Blue Shield group coverage after the initial enrollment period is not considered a late enrollee if the employee:

- Was covered under another group-sponsored health plan at the time he or she was eligible to enroll; and
- Certified on the Refusal of Personal Coverage section of the Employee Application during initial enrollment that he or she declined enrollment because he or she was covered under another group-sponsored health plan (individual and family plans do not qualify as another group-sponsored health plan); and
- Lost or will lose coverage under his or her other group-sponsored health plan due to any of the following six situations:
  1. Employment of the original plan subscriber (such as the employee's spouse or domestic partner) is terminated.
  2. Employment status of the original plan subscriber (such as the employee's spouse or domestic partner) changes. For example, the employee's spouse begins working as a part-time employee rather than a full-time employee.
  3. The other group-sponsored coverage is terminated.
  4. The company sponsoring the other group-sponsored health plan is no longer contributing to coverage. For example, if your employee's spouse's company stops contributing to coverage under its health plan, your employee could apply for Blue Shield coverage and would not be considered a late enrollee.
  5. The original subscriber of the employee's health coverage dies.
  6. Your employee gets a divorce from the original subscriber of the other group coverage.

The employee must request enrollment in a Blue Shield group plan within 60 days of losing the other group-sponsored coverage. You should submit requests to add individuals to your Blue Shield group plan within 60 days of the event. Due to state law, Blue Shield cannot consider exceptions to the 60-day time frame for small groups. Please note that a dependent is not considered a late enrollee if:

- A court orders the employee to provide medical coverage for a spouse or minor child; or
- The dependent loses coverage under Medi-Cal or the Healthy Families Program.

Member ID cards

The member ID cards identify your employees as a Blue Shield member. Your employees should carry their Blue Shield member ID cards with them at all times. We will issue a combination medical and prescription drug identification card to employees approximately two weeks after they enroll in your Blue Shield group plan. Dependents will not receive separate identification cards. If you offer Blue Shield dental coverage, we'll issue them a separate dental ID card. Please advise your employees to immediately review their card for accurate information. If there is an error, they will need to call customer service to avoid any issues with accessing care or billing.

For additional cards, members can log in to **blueshieldca.com** and click on *View/Print ID Card*, or call the number listed on their Blue Shield medical ID card. If they have lost their card, they can log in to **blueshieldca.com** and click on *View/Print ID Card* or call customer service at **(800) 218-8601**. HR Administrators can also order Blue Shield medical cards within Employer Connection.

Dental ID cards are delivered separately from the medical ID cards.

For vision plan information cards, which help employees use their vision coverage, you can log in to **blueshieldca.com/employer** and look for vision plans. The link to vision cards is at the bottom of the page.

Credit for prior coverage

We will provide our members who terminate their Blue Shield coverage with written certifications of their creditable coverage. This will be based on their enrollment date, which is either the effective date of Blue Shield coverage or, if there is an eligibility waiting period, the beginning of that waiting period (usually the date of hire).

HMO ID card sample


blue of california

Subscriber
John Doe

ID# **XEAJ12345678**
Copayments
Office **$20**
Group# **H1F003**
Effective **01/01/17**
Plan **HMO**
Rx **Yes**

BROWN AND TOLAND MEDICAL GROUP A+
DAVID M JONES MD
(415) 228-5867
JOHN D
effective 01/01/17
SUE D
effective 01/01/17
BROWN AND TOLAND MEDICAL GRP A+
LAURA J MARTIN MD
(415) 225-4438
ANNA D
effective 01/01/17


blue of california

blueshieldca.com

Providers: Please file all claims with your local BlueCross BlueShield licensee in whose service area the member received services or, when Medicare is primary, file all Medicare claims with Medicare.

California Providers: Call Provider Customer Service to obtain medical and hospital admission prior authorization to avoid reduced or non-payment. Call Specialists Call for prescription processing information. Visit Provider Connection at **blueshieldca.com/provider.**

CA Medical claims to: Blue Shield of California P.O. Box 272540, Chico, CA 95927-2540

(800) 443-5005 Member Services
(800) 241-1823 TTY
(877) 263-9952 Mental Health Customer Service
(877) 304-0504 NurseHelp 24/7
(800) 595-2405 LifeReferrals 24/7
(800) 810-2583 To locate providers outside of California
(800) 541-2583 CA Provider Customer Service (including hospitals)
(888) 635-8224 PharmacistsOnly

A+ gives you the option to self-refer to an Access+ Specialist, subject to certain limitations. See your *Evidence of Coverage* for details.

Blue Shield of California is an independent member of the Blue Shield Association

PPO ID card sample


blue of california

Subscriber
John Doe
ID#
XEAJ12345678

Group# **930876**
Effective **01/01/17**
Coverage **Individual**
Plan **PPO**
Rx **Yes**
Language **Spanish**

Top message


blue of california

blueshieldca.com

Members: Use Blue Shield of California preferred providers to receive maximum benefits. In case of emergency, call 911 or seek appropriate emergency care.

Providers: For Provider Connection visit **blueshieldca.com/provider.** Please file all claims with your local BlueCross BlueShield licensee in whose service area the member received services or, when Medicare is primary, file all Medicare claims with Medicare.

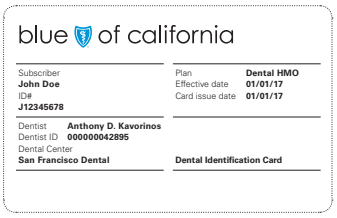
Blue Shield of California is an independent member of the Blue Shield Association.

(800) 200-3242 Customer Service
(866) 216-9926 TTY
(877) 263-7178 Mental Health Customer Svc.
(866) 543-3728 NurseHelp 24/7, LifeReferrals 24/7
(800) 810-2583 To locate providers outside of California

Providers (including hospitals and pharmacies):
(800) 541-6652 Provider Customer Service
- To avoid reduced or non-payment, call to obtain medical and hospital admission prioauthorization.
- Call for prescription processing information.

Medical claims to: Blue Shield of California P.O. Box 272540, Chico, CA 95927-2540

Dental PPO ID card sample

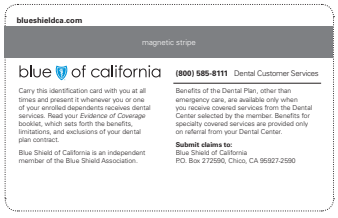

blue of california

Subscriber
John Doe
ID#
J12345678

Plan **Dental HMO**
Effective date **01/01/17**
Card issue date **01/01/17**

Dentist **Anthony D. Kavorinos**
Dentist ID **000000042895**
Dental Center
San Francisco Dental

Dental Identification Card


blueshieldca.com

magnetic stripe

blue of california

(800) 585-8111 Dental Customer Services

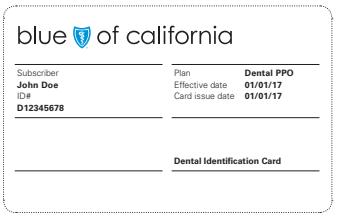
Carry this identification card with you at all times and present it whenever you or one of your enrolled dependents receives dental services. Read your *Evidence of Coverage* booklet, which sets forth the benefits, limitations, and exclusions of your dental plan contract.

Blue Shield of California is an independent member of the Blue Shield Association.

Benefits of the Dental Plan, other than emergency care, are available only when you receive covered services from the Dental Center selected by the member. Benefits for specialty covered services are provided only on referral from your Dental Center.

Submit claims to:
Blue Shield of California
P.O. Box 272590, Chico, CA 95927-2590

Dental HMO ID card sample


blue of california

Subscriber
John Doe
ID#
D12345678

Plan **Dental PPO**
Effective date **01/01/17**
Card issue date **01/01/17**

Dental Identification Card


blueshieldca.com

magnetic stripe

blue of california

(888) 271-4929 Dental Customer Services

Carry this identification card with you at all times and present it whenever you or one of your enrolled dependents receives dental services. Read your *Evidence of Coverage* booklet, which sets forth the benefits, limitations, and exclusions of your dental plan contract.

Your dental plan has expanded the PPO network to include the CONNECTION Dental Network.

Blue Shield of California is an independent member of the Blue Shield Association.

Network benefits apply when you receive covered services from a network dentist. In-network benefits are paid based on applicable copayment. For non-network benefits, you will be reimbursed up to a specified maximum amount and will be responsible for the remainder of the dentist's billed charges.

Submit claims to:
Blue Shield of California
P.O. Box 272590, Chico, CA 95927-2590

Employee status changes

Name and address changes

For an employee whose name is legally changed, who wants to make a name correction, or who has moved to a new home address you should make changes online through Employer Connection.

Leave of absence

When an employee takes a leave of absence consistent with your company's personnel policy, you do not have to take any special action regarding the employee's Blue Shield coverage.

If your company requires employees to pay for their group health plan coverage during the leave period, payment must be made payable to your company and not to Blue Shield. We will continue to include the name of the employee on leave on your monthly billing statement.

If an employee is on an approved family leave and your company is subject to the federal Family and Medical Leave Act of 1993, payment of the employee's dues will keep coverage in force for the periods allowed by the Act.

The allowable length of a leave of absence is determined by your company's personnel policy. Therefore, your company policy determines when the employee on leave is terminated. When you terminate an employee, you must notify Blue Shield through Employer Connection at **blueshieldca.com/employer**. When an employee on leave is terminated, he or she may qualify for continuation coverage in the same manner as a terminated employee who was actively working on his or her last day of coverage.

Divorce or legal separation

When an employee divorces, his or her dependent children do not lose eligibility and may continue to be covered as the employee's dependents. If the employee decides to cancel the children's group coverage, they may elect COBRA (Consolidated Omnibus Budget Reconciliation Act) or Cal-COBRA continuation coverage on their own within the 60-day election period.

The former spouse does lose eligibility under the group plan, but may be eligible for COBRA or Cal-COBRA continuation coverage.

For more information, see the Coverage Cancellation section starting on page 27.

Termination of domestic partnership or divorce of same-gender spouse

When a domestic partnership terminates or a same-gender spouse is divorced, group coverage of the employee's domestic partner or same-gender spouse and his or her children will terminate at the end of the month in which the domestic partnership termination or divorce occurs. The employee's domestic partner or same-gender spouse and children are not eligible for federal COBRA coverage. However, eligibility requirements for continued coverage under Cal-COBRA are different from those of federal COBRA, so they may be eligible for Cal-COBRA coverage.

The employee must provide you with the domestic partner's or same-gender spouse's forwarding address so that the individual can receive the appropriate Cal-COBRA notification by mail. Please send the information to Cal-COBRA, P.O. Box 629009, El Dorado Hills, CA 95762-9009 or by fax at **(916) 350-7480**, within 60 days of the qualifying event date.

You can administer address changes by visiting Employer Connection at **blueshieldca.com/employer.**

For ownership or group name change

Be sure to keep your small group information current, especially if you have a change of ownership or a name change. This would include the sale of your business that results in any of the following: new ownership, new business entity, merging with another business entity and becoming a subsidiary, sale of assets and liabilities of that entity, or a simple name change or sale of company stock. For any of these examples, please contact your broker or your Blue Shield small business account manager so they can walk you through a Name Change checklist over the phone quickly and easily. Once complete, your group information will be processed.

Claims process (for PPO plans only)

Here's what your employees need to know about claims:

Participating providers

An employee who uses a participating provider should never have to complete a claim form, because these providers bill Blue Shield directly. In the rare instance when a participating provider requests payment from the employee, the employee should ask the provider to call the number listed on their Blue Shield member ID card. Blue Shield will determine whether or not the employee is responsible for any part of the bill (the deductible or copayment). For any amount beyond that, the participating provider should bill Blue Shield directly.

Non-participating providers

If a non-participating provider asks your employee for payment immediately after the visit, the employee should:

- Pay the bill; and then
- Mail the itemized bill, along with a Subscriber's Statement of Claim form, to Blue Shield at the address listed in the Forms section starting on page 44.

Employees should send Blue Shield a claim form for all covered services even if they have not yet met their calendar-year deductible. This allows us to accurately keep track of deductibles. Blue Shield will reimburse the employee for the plan-covered benefit payment minus the deductible and copayment amounts.

Explanation of Benefits

An Explanation of Benefits (EOB) explains the actions taken on each claim an employee or provider submits. The EOB tells an employee how a submitted claim was processed and informs the employee of any financial responsibility.

The EOB is not a bill. However, it will reference any copayments the member owes for services. If the employee has any financial responsibility for the claim, he or she will receive a bill from the provider of service.

Members who receive medical services outside Blue Shield's service area should refer to the BlueCard Program section of their plan's *Evidence of Coverage* or *Certificate of Insurance* when submitting claims.

Paperless delivery of Explanation of Benefits (EOB) provides members with both faster delivery and easier access to their claims information. Direct your clients to **blueshieldca.com/gopaperless** to sign up for this new service.

When your employees are registered on **blueshieldca.com**, they can see highlights and details of their health plan coverage, understand their copayments and deductibles, and check the status of their claims simply by logging in and clicking on *My Plan & Claims*. They can also change their Personal Physician, order replacement ID cards and verify their benefits for certain services. Encourage your employees to register today!

Grievance process

Blue Shield of California and Blue Shield of California Life & Health Insurance Company (Blue Shield Life) have grievance procedures for receiving, resolving and tracking member grievances. Employees, their providers, or attorneys or representatives on behalf of employees can contact our Customer Service representatives by telephone, online at **blueshieldca.com**, or by letter to request an initial review of a claim or service. Employees can reference their *Evidence of Coverage* or *Certificate of Insurance* for a detailed overview about how to file a grievance, or log in to **blueshieldca.com** and click on *Grievance Form* at the bottom of the screen.

Coverage cancellation and options for employees

Employees or dependents who no longer qualify for your group's Blue Shield coverage may be eligible for extended coverage under COBRA or Cal-COBRA. Please advise employees who are considering continuing group coverage under COBRA or Cal-COBRA to consider these options carefully before they investigate individual health insurance.

When an employee's or dependent's coverage under your plan is cancelled, you should:

- Report the coverage cancellation by calling our Group Employer Services Department or by filling out an Employee Change Transmittal form.
- Notify us prior to each individual's last day of eligibility, whenever possible.

Please note that Blue Shield does not participate in severance pay. Coverage for an individual no longer employed with the company will need to be cancelled the first of the month following a qualifying event. If your group has a 15th of the month effective date, an employee cancellation will be effective the 15th of the month following the qualifying event.

Employee and dependent coverage changes and cancellation

Employee coverage cancellation

Employees are no longer eligible for Blue Shield group coverage when their employment is terminated, on Leave of Absence (LOA), or their employment hours are reduced to fewer than 30 hours per week, unless they are covered under provisions of state law that allow coverage of part-time employees. To cancel an employee's coverage, here are your options:

1. Once registered on Employer Connection, you can easily cancel employee and dependent coverage online. Please visit **blueshieldca.com/ecp-getting-started** to learn more.

   Cancellation requests must be submitted within 60 days of the termination date.

2. Groups eligible for Cal-COBRA will need to submit the Cal-COBRA Employer Notification of Qualifying Events form within 60 days and be sure to include reason for cancellation, last day worked and valid address and phone number.

Helpful hints:

- When an employee's coverage is cancelled, all covered dependents lose eligibility and their group coverage is cancelled automatically.
- If an employee voluntarily cancels his or her group coverage (when not terminating employment with your company), a Refusal of Coverage form must be submitted. If the employee later wishes to re-enroll, the employee must comply with the late enrollee guidelines, outlined on page 22, or wait until open enrollment. Please note that a Refusal of Coverage is not a COBRA or Cal-COBRA qualifying event. You do not need to submit anything to Cal-COBRA, but the group will need to submit the Refusal of Coverage form with a cancellation request in order to have the employee removed from billing.
- Employees must be a resident of California in order to be eligible for COBRA coverage if enrolled in an HMO plan. However, non-residents may be eligible to transfer to a PPO plan if you offer one. Please contact your Blue Shield account manager about continuation coverage for your out-of-state employees.
- For Cal-COBRA groups (2 to 19 eligible employees), employers should complete the Employer Notification of Qualifying Events under Cal-COBRA form so the employee can be notified of their Cal-COBRA options.
- If you are cancelling an employee on a vision plan but not a Blue Shield medical plan, go to **blueshieldca.com/ecp-getting-started**. If you have any questions, call the vision plan administrator at **(877) 601-9083**.
- When a specialty product is sold with medical coverage, and the group elects to cancel its medical coverage, we will cancel only its medical coverage and maintain the dental, life,* or vision coverage unless specifically requested to cancel the specialty product.

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

Dependent coverage cancellation

Dependents are no longer eligible for Blue Shield group coverage when the employee through whom they were covered dies, terminates employment, or no longer works the minimum hours required for eligibility.

Coverage for dependent children will be cancelled when they reach age 26 unless certified as an over-age disabled dependent. Cancellation is effective the first day of the month following their 26th birthday.

The pediatric and dental vision benefit for dependent children will be cancelled when they reach age 19 (unless certified as an over-age disabled dependent); however, the specific cancellation date of coverage varies for pediatric dental and vision benefits.

- Pediatric dental coverage: Eligibility for the pediatric dental benefit ends on the last day of the month the child dependent turns age 19. For example, a child dependent who turns age 19 on April 15, will be eligible for dental benefits until April 30.
- Pediatric vision coverage: Eligibility for the pediatric vision benefit ends on the last day of the plan year following the dependent's 19th birthday. For example, a child dependent who turns age 19 on April 15, will be eligible for vision benefits until the group's plan year ends.

The following dependents may be eligible for continued coverage under COBRA or Cal-COBRA:

- A spouse who divorces or legally separates from a covered employee and becomes ineligible for group coverage.
- The subscriber's dependent children if the subscriber decides to cancel the dependent children from his or her coverage.
- When a domestic partnership terminates, group coverage of the employee's domestic partner and his or her children will terminate at the end of the month in which the domestic partnership termination occurs. The employee's domestic partner and children may be eligible for continued coverage under Cal-COBRA. For details, see the Employee Status Changes section on page 25.
- When a same-gender spouse is divorced, group coverage of the employee's same-gender spouse and his or her children will terminate at the end of the month in which the divorce occurs. The employee's same-gender spouse and children may be eligible for continued coverage under Cal-COBRA. For details, see the Employee Status Changes section on page 25.

Please note: Federal COBRA does not require continued coverage for the same-gender spouse or children when the divorce occurs because a same-gender spouse is not considered a legally married spouse under federal law. Federal COBRA does not require continued coverage for domestic partners except when the employee elects COBRA and enrolls the domestic partner as a dependent.

Employees are responsible for informing you when a dependent is no longer eligible for coverage. To cancel a dependent's coverage when the employee continues to be covered, simply go to **blueshieldca.com/ecp-getting-started.**

Note: If your group is qualified under Cal-COBRA, you are required to send a separate notification to the Cal-COBRA department at Blue Shield within 60 days of an individual's qualifying event date.

Please note: Cancellation requests must be submitted within 30 days of the termination date. Retroactive cancellations that exceed 30 days will not be approved for small businesses.

State Cal-COBRA and federal COBRA continuation coverage

To determine which type of continuation coverage your group is subject to, please review the information below.

General guidelines

Cal-COBRA is a state mandate and generally applies to employers that employed 2 to 19 employees for at least 50% of the working days in the previous calendar year.

COBRA continuation coverage is a federal mandate and generally applies to employers that employed 20 or more employees during at least 50% of the working days in the previous calendar year.

When the number of employees either increases to more than 19 or decreases to fewer than 20, you wait until the first day of the next calendar year to change your administration of continuation of group coverage from Cal-COBRA to COBRA or from COBRA to Cal-COBRA.

A group's COBRA or Cal-COBRA status needs to be reported to Blue Shield in January each year regardless of what the group's contract renewal date is. Changes to the group's status for COBRA or Cal-COBRA are effective on January 1. Any exceptions or request to change after the January 1 effective date is reviewed on a case-by-case basis.

Cal-COBRA administration

Blue Shield administers Cal-COBRA for small employers not subject to COBRA. Keep in mind, you may not administer your own Cal-COBRA coverage.

Notice to Blue Shield of Cal-COBRA qualifying event

Under Cal-COBRA, you are required to notify Blue Shield within 60 days of an employee's termination or ineligibility due to a reduction of work hours.

To notify us, please complete an Employer Notification of Qualifying Event Under Cal-COBRA form and mail or fax it to the contact listed under Where to Send Blue Shield Forms. After we receive the notification, we will mail information to the employee regarding Cal-COBRA benefits, rates and enrollment.

Our dedicated Cal-COBRA team will perform the following administrative functions for your employees eligible for Cal-COBRA:

- Provide Cal-COBRA packets to eligible applicants (your employees and/or their dependents) within 14 days of receiving a qualifying event notice from the employer or eligible individual
- Collect monthly payments for the Cal-COBRA coverage
- Answer customers' billing and eligibility questions
- Process cancellations

Cal-COBRA enrollees are eligible to continue Cal-COBRA coverage for up to a maximum of 36 months regardless of the type of qualifying event.

Please note: Cal-COBRA coverage is linked to the employers' group benefits policy. Any changes or cancellation of the employer's coverage will also apply to Cal-COBRA enrollees. If you change carriers, you must notify Cal-COBRA, P.O. Box 629009, El Dorado Hills, CA 95762-9009 or by fax at **(916) 350-7480**, so that Blue Shield can prepare a list of members covered by Cal-COBRA for you to transition to a new carrier.

COBRA coverage

Blue Shield of California does not provide federal COBRA administration services. All employers are responsible for administering their own federal COBRA program.

Groups have the option to self-administer their federal COBRA benefits, use a third-party COBRA administrator, or use Blue Shield's preferred COBRA administrator, Conexis. You can contact Conexis at (877) 266-3947 or bscsales@conexis.com. For general information regarding Conexis, go to www.conexis.org.

COBRA disability extension

A member may extend his or her 18-month COBRA period to 29 months if, under the Social Security Act, the member is determined to be:

1. Disabled on or before the date of termination or reduction in hours of employment, OR
2. Disabled within the first 60 days of the initial qualifying event, AND
3. Notification is given to the employer or Blue Shield before the end of the 18-month period. The member is responsible for notifying the employer or Blue Shield within 30 days of any final determination affecting his or her disability status.

Dues for months 19 through 29 are calculated at 150% of your group dues rate.

Cal-COBRA coverage for COBRA enrollees

Individuals enrolled in COBRA who reach the 18-month or 29-month maximum available under COBRA may elect to continue coverage under Cal-COBRA for a maximum period of 36 months from the date the person's continuation coverage began under COBRA. In no event will coverage extend beyond 36 months under the combination of COBRA and Cal-COBRA.

These conditions apply:

- If elected, the Cal-COBRA coverage will begin after the COBRA coverage ends and will be administered by Blue Shield's Cal-COBRA Administration.
- Individuals enrolled in COBRA must exhaust all the COBRA coverage to which they are entitled before they can become eligible to continue coverage under Cal-COBRA.
  - Eligible individuals not eligible for COBRA may apply directly for Cal-COBRA, for example, domestic partners when the partnership terminates and same-gender spouses when divorce occurs.
  - When a domestic partnership terminates, same-gender spouses divorce, or an employee dies, the domestic partner or same-gender spouse may apply for continuation of group coverage under Cal-COBRA.

Cal-COBRA notification requirements for COBRA plan administrators

The eligible individual should contact Blue Shield for more information about Cal-COBRA continuation coverage.

The employer group or its COBRA administrator is responsible for notifying COBRA enrollees of their right to continue coverage under Cal-COBRA at least 90 calendar days before their COBRA coverage will end. If the individual wants to apply for continuation of coverage under Cal-COBRA, the individual must notify Blue Shield at least 30 days before COBRA terminates.

Coverage options for employees and retirees who have Medicare coverage

Employees and dependents with Medicare coverage have other health coverage options, including those described below.

Under COBRA, an enrollee is entitled to COBRA coverage if at the time of the qualifying event, the enrollee is already entitled to Medicare (or has coverage under another group health plan). However, under Cal-COBRA continuing coverage is not available if the enrollee is entitled to Medicare or other group coverage. Under both COBRA and Cal-COBRA, if Medicare entitlement (or coverage under another group health plan) arises after continuation coverage begins, that continuation coverage will cease.

Active employees

Employers with 20+ employees

Employers subject to the Medicare secondary payer laws (generally those with 20 or more employees) may not discriminate against their employees who have become eligible for Medicare benefits:

- The employees' benefits and contributions to the cost of coverage must be the same as those for employees who are not eligible for Medicare.
- Group coverage is primary, and Medicare coverage is secondary.

Special enrollment periods are also available to individuals who have exhausted their COBRA and/or Cal-COBRA coverage. At that point, they may apply for an individual and family plan from Blue Shield or any other carrier as long as they meet general eligibility requirements. Plan options may vary based on where an individual lives and by carrier. However, all plans are available without consideration of pre-existing conditions.

Extension of benefits for disabled members

Extension of benefits is granted only to members who become totally disabled while covered under the plan and remain totally disabled when the group contract is cancelled. Blue Shield will extend the benefits, subject to all limitations and restrictions, for covered services and supplies directly related to the disabling condition, illness, or injury until the first to occur of the following:

- 12 months from the date coverage terminated.
- The date the covered person is no longer totally disabled.
- The date the covered person's maximum benefits are reached.
- The date a replacement carrier provides coverage to the person without limitation as to the totally disabling condition.

A licensed physician must submit to Blue Shield a written certification of the member's total disability within 90 days of the date coverage was terminated. The member's physician must then furnish proof of continuing total disability at reasonable intervals determined by Blue Shield.

Filing for an extension of benefits for disabled members

To file for an extension of benefits:

- The employee must complete a Subscriber Statement of Disability form, and
- You must complete a Notice of Total and Permanent Disability form and then mail both forms to the Program Management/Extension of Benefits address listed under the Forms section starting on page 44.
- The disabled member's primary physician must submit an Attending Physician Statement of Disability form to Blue Shield at the address listed in the Forms section starting on page 44.

Blue Shield chooses to offer reduced rates to our clients to help mitigate the cost of coverage. To continue to receive reduced rates, please provide us with a copy of your DE-9C (two quarterly statements) to confirm your status as a small group, as defined by Medicare.

For additional coverage options for employees and dependents, please go to **blueshieldca.com/employer**, and click on *Small Group Plans (1-50) under Medical Plans & Benefits*. You can also contact your Blue Shield broker
to learn about:

- Blue Shield Individual and Family Plans (IFPs)
- Blue Shield individual conversion plans
- Medicare Coordination of Benefits (COB) plan or Blue Shield 65 Plus℠ (HMO) for individuals with Medicare
- Individual Senior Guard Plan for retirees without Medicare coverage

To keep our promise of excellent service, we have experienced teams dedicated to your group plan administration needs, including two teams that concentrate specifically on group reconciliation and billing issues.

Managing your medical coverage

Billing procedures

The following sections explain our billing procedures and requirements.

Paying your bill

Blue Shield will send you a monthly bill, called a Group Payment Request. It has billing details by subgroup and a Group Summary page. You should:

- Submit any cancellation requests within 60 days of the termination date. Retroactive cancellations that exceed 60 days will not be approved.
- Verify monthly that your changes are accurately reflected on the Group Payment Request.
- Submit the Group Summary page with your monthly dues to the address listed on your monthly bill with the proper allocations listed in the amount paid field beside each group number.
- Easily pay your bill or set up automatic payments online using Employer Connection.

Please note: If you recently submitted a change, the change may not be reflected until the following month's bill.

If you submitted additions, cancellations, or transfers during the billing period, you do not need to make any billing adjustments if they do not appear on your monthly bill. Simply pay the amount shown on your current Group Payment Request and we will credit or debit your account for the correct amount on your next Group Payment Request.

If you have questions regarding billing discrepancies, please call your Blue Shield group billing representative at **(800) 325-5166**.

Blue Shield is a prepaid health plan, so we must receive your group's dues on or before the due date to keep your coverage current. An "unpaid" status could cause your group's coverage to be suspended or cancelled.

Pay your bill online at Employer Connection. Register at **blueshieldca.com/employer** and get started today.

TIP!

Reporting changes, additions and cancellations to your group's coverage in a timely manner will help avoid unnecessary delays. It's easy when you use **blueshieldca.com/employer**.

If you have any questions about changes to your group's coverage, please contact Group Membership Eligibility Customer Service at **(800) 325-5166** or email **small.group@blueshieldca.com**.

Paying dues for new additions

You do not need to pay dues for new employees or dependents until we bill you on your next Group Payment Request. Please note that you are responsible for verifying that the request is being processed by reading over your Group Payment Request each month, and making sure the dues for new employees or dependents are on the bill.

Stopping payment for cancellations

If an employee is terminated during the month:

- Please submit the cancellation request online.
- The employee's coverage will remain in force until the end of the billing period, and dues are payable for that period.
- The terminated employee will be deleted from the next Group Payment Request.
- If you report coverage cancellation of an employee or dependent and it doesn't appear on your next monthly bill, do not make any billing adjustment. Simply pay the total that appears on your current bill and we will credit you for the deleted dues on your next Group Payment Request.

Delinquency

Here's what you need to know about our delinquent notification policy and procedures:

- Blue Shield is a prepaid health plan. You will be billed prior to the payment due date.
- Group dues are delinquent on the day following the due date printed on the Group Payment Request.
- Group coverage will be cancelled for nonpayment if dues are not received in a timely manner.
- We will notify a delinquent account 15 days prior to cancelling the account for nonpayment.
- When dues payment is received in full before cancellation, the delinquent status will be removed from the account.

Late payment notice

We will issue a Prospective Notice of Cancellation when we haven't received dues by 15 days after the due date. This notice contains:

- The total amount due, including delinquent dues and current charges
- Advance notice of cancellation for nonpayment of dues, along with the cancellation effective date
- A pre-addressed envelope for submitting the dues

If you submit payment on time and receive the Prospective Notice of Cancellation in error, please contact your group billing representative at **(800) 325-5166** or email **small.group@blueshieldca.com**.

Cancellation procedures

Requesting cancellation of your group account

We require 30 days' advance written notice of cancellation. You can send notification by sending a letter on business letterhead.

We will reconcile your account to the effective date of cancellation and send written notification of your account's status to your billing address on record.

In addition, you will need to contact the Cal-COBRA department to verify if you have any Cal-COBRA members as they do not appear on your billing but will need to be transitioned along with your group. Contact **(800) 228-9476** for more information.

Administrative cancellation

If your group no longer meets the eligibility requirements defined by state law (see the Eligibility Requirements section starting on page 13), you will be notified prior to your renewal and given 30 days to respond to our request for documents confirming your group's continued eligibility for renewal. If your group is not compliant with eligibility requirements, your small group coverage will not be guaranteed renewable. If we do not receive requested information to confirm eligibility, your group may not be eligible for renewal.

Please note:

If your group account coverage is cancelled for any reason, you are responsible for immediately notifying your employees and COBRA/ Cal-COBRA beneficiaries about the coverage termination.

Nonpayment of dues

We consider an account delinquent when we do not receive the group dues by the due date printed on the Group Payment Request. Here is the procedure for delinquent accounts:

- We will send you an Intent to Cancel Notice (Prospective Notice of Cancellation) 15 days after the due date to notify your group of the delinquent status. This notice serves as the 15-day notice of cancellation as required by state law. If we do not receive payment of all outstanding dues within 15 days after mailing the Intent to Cancel Notice, we will cancel the account for nonpayment of dues on that date. The effective date of the cancellation will be 30 days after the bill due date listed on your Group Payment Request unless requested otherwise.
- You will remain financially responsible for all outstanding dues incurred while the account was in effect.
- We will then mail you a notice confirming termination of coverage. You must promptly notify your employees of the cancellation of your employer group plan by providing them with a copy of this notice. If your account is cancelled, benefits will not be provided for any services incurred by your employees and dependents after the cancellation date.

Please note: Reinstatement requests may be considered at our sole discretion and are not guaranteed. You may submit a written request for consideration to the Small Group Cancellation email box at **LgpCan01@blueshieldca.com** or fax **(209) 367-6369**. Please allow 72 business hours for a response.

If you transfer group coverage to another carrier or there is another reason for cancellation, please notify us rather than letting the account cancel for nonpayment.

How to manage your group dental benefits

We've designed the following section to make it easier for you to manage your group dental plan if you've selected Blue Shield dental coverage for your employees.

Under the Affordable Care Act (ACA), pediatric dental coverage is an Essential Health Benefit. Note that all eligible dependent children to the age of 19 must have dental coverage as an embedded benefit of their medical plan; however, employees and dependents who are 19 to 26 years old will not receive pediatric dental coverage and, therefore, will not be required to pay any premiums.

Pediatric dental coverage, an Essential Health Benefit as defined in the ACA, is an embedded benefit in a group's Blue Shield medical plan.

When you purchase dental coverage along with your Blue Shield medical plan, you enjoy the advantages of joint administration:

- Single enrollment form
- Single point of contact for adding and removing employees and their dependents

Enrolling employees and dependents

As new employees and their dependents become eligible for benefits, or once they have fulfilled your company's benefits waiting period, they should complete a new Employee Application (C12914) with the online submission.

Employee status change

You are responsible for maintaining accurate eligible employee information.

- Changes must be completed online when there is a change in status to employees, or their dependents, spouse, or domestic partner.
- In cases of births, adoptions, marriages and divorces, you must submit changes online no later than 60 days after the change.
- If the changes are not submitted within 60 days of change, they will need to wait until your group's next open enrollment period.
- If an employee decides to add coverage for an existing dependent or spouse, the employee must wait until your group's next open enrollment period.

Invoice procedures

Fax or mail membership changes to Blue Shield. They will be reflected on the following month's invoice and Add/Change/Terminate Report. It is important to pay the amount shown on the invoice. Please do not subtract terminating employees' dues from the amount due as it will result in a negative balance on the next month's bill. Termination information should be submitted on the Employee Change Transmittal form (C3843). The amount will be credited on the next billing cycle.

Open enrollment

Approximately 45 days prior to your group's renewal date (the anniversary date of the group's contract), you should schedule an open enrollment period to help your employees understand their benefits and options. For assistance in planning your group's open enrollment period, please contact your broker or Blue Shield account manager.

Dental HMO plan provider change

Dental HMO members may change their current dental provider at any time by calling Dental Member Services at **(800) 585-8111**. Changes are effective the 1st of the following month.

Nationwide dental provider network

In addition to the large California provider network, the national network[1] helps meet the needs of California employers who have out-of-state employees. Blue Shield offers all members with dental coverage access to a nationwide dental provider network to receive care from preferred dental providers – just like employees in California.

Members can identify whether a particular dentist is in the provider network or get a listing of providers in the Blue Shield dental PPO, INO, or HMO network by:

- Going to **blueshieldca.com** to find a provider
- Calling Dental Member Services at **(888) 702-4171**

Submitting a claim

Dental HMO plan claims handling

- There are no claim forms required for general dental procedures.
- If any services require a copayment, the member is expected to pay the copayment at the time of service.
- For treatment requiring the services of a dental specialist (endodontist, periodontist, oral surgeon, orthodontist, or pedodontist), the general dentist will make a referral. Subsequent forms and claims will be the responsibility of the specialist.

Dental PPO plan claims handling

- Providers in the dental PPO network will submit claims for payment after services have been received by the members.
- Members are required to submit a Dental Claims form (C11716) for services if they received services from a non-network provider.
- Providers in the dental PPO network agree to accept the Blue Shield of California payment as payment in full.
- Non-network providers have not agreed to accept Blue Shield of California's payment as payment in full, and the member may be responsible for the difference between the amount reimbursed and the amount billed by the non-network provider.

Dental INO* plan claims handling

- Providers in the dental INO (in-network only) network will submit claims for payment after services have been received by the members.
- Providers in the dental INO network agree to accept the Blue Shield of California Life & Health Insurance Company payment as payment in full.

Manage your dental members online

Manage your dental members easily online using Employer Connection. Forms for administering group dental benefits can be printed from **blueshieldca.com** or ordered by contacting your Blue Shield account manager.

Dental Member Services

Dental Member Services can assist you with questions about eligibility or claims. For questions about your plan or renewal rates, please contact your Blue Shield account manager.

Dental Member Services
Dental HMO: **(800) 585-8111**
Dental PPO and INO: **(888) 702-4171**

Monday through Friday, 5 a.m. to 8 p.m. PST

Grievance process

Members, their providers, or attorney or representatives on behalf of members can contact our Dental Member Services representatives by telephone, online at **blueshieldca.com**, or by letter to request an initial review of a claim or service.

Dental Member Services can assist in completing the grievance form. Completed grievance forms must be mailed to:

Blue Shield of California
Dental Plan Administrator
425 Market St., 15th Floor
San Francisco, CA 94105

The Dental Plan Administrator will acknowledge receipt of a written grievance within five calendar days. Grievances are resolved within 30 days. The grievance system allows members to file grievances within 180 days following any incident or action that is the subject of the member's dissatisfaction.

Please note: If an employer's health plan is governed by the Employee Retirement Income Security Act ("ERISA"), employees may have the right to bring civil action under Section 502(a) of ERISA if all required reviews of a claim have been completed and a claim has not been approved.

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

1 Dental providers nationwide and in California are available through a contracted dental plan administrator.

How to manage your group vision benefits

We've designed the following to make it easier for you to enroll and manage your group vision plan if you've selected Blue Shield vision coverage for your employees. Note, under ACA, pediatric vision coverage is an Essential Health Benefit. Note that all eligible dependent children to the age of 19 must have vision coverage as an embedded benefit of their medical plan; however, employees and dependents who are 19 to 26 years old will not receive pediatric vision coverage and, therefore, will not be required to pay any premiums.

Enrolling employees and dependents

If you purchased a Blue Shield vision plan with your Blue Shield medical plan, you receive advantages of joint administration:

- Single enrollment form for both vision and medical coverage.
- Single point of contact for adding and removing employees and their dependents. If you have a Blue Shield vision plan with your medical coverage, you can easily add new employees, their spouse/domestic partner, and dependents on Employer Connection.
- Single bill for both medical and vision plans.

Employee status change

You are responsible for maintaining accurate eligible employee information.

- Each month you will receive a premium billing statement, which includes all eligible members for the next month. Review your premium billing statement to confirm accurate eligible employee information.
- A change request must be completed online when there is a change in status to an employee's dependents, spouse, or domestic partner.
- For terminations, use the Employee Change Transmittal form (C3843).
- Complete and return the Eligibility Control form included with your bill with any enrollment changes. You can submit this form each month noting the enrollment changes.

Pediatric vision coverage, an Essential Health Benefit as defined in the ACA, is an embedded benefit in a group's Blue Shield medical plan.

Invoice procedures

It is important to pay the amount shown on the invoice. Please do not subtract terminating employee's dues from the amount due as it will result in a negative balance on the next month's bill. The amount will be credited on the next billing cycle.

Open enrollment

Approximately 45 days prior to your group's renewal date (the anniversary date of the group's contract), you should schedule an open enrollment period to help your employees understand their benefits and options. For assistance in planning your group's open enrollment period, please contact your broker or Blue Shield account manager.

Nationwide vision provider network

In addition to having one of California's largest provider networks, Blue Shield helps to meet the needs of California employers who have out-of-state employees. Blue Shield members get vision coverage access to a nationwide vision provider network so they can receive care from preferred vision providers – just like employees in California.

- To find a provider in California, go to **blueshieldca.com/fap**.
- For out-of-state providers, go to **blueshieldcavision.com**.

Vision plan information card

Each member can receive a vision plan information card for use when seeking services. The card is not required, but has useful information for both the member and the provider. Cards will be included with new enrollment materials, and additional cards can be downloaded on **blueshieldca.com/employer**, under *Vision Plans*. Or, you can call Vision Member Services at **(877) 601-9083**.


blue of california

Vision plan information card

Here's how to get vision services:

1. Select a network provider by visiting the *Find a Provider* section of **blueshieldca.com.**
2. Make an appointment directly with the provider you select.
3. Tell your provider that you have Blue Shield* vision care through MESVision.

* Blue Shield vision plans are underwritten by Blue Shield of California Life & Health Insurance Company, and are administered by MESVision.

This vision plan information card is to assist you in using your vision coverage. This card is not required to access care, and is not a verification of eligibility. The vision provider will verify your eligibility by calling the number listed below.

Here to help

Members

If you have any questions about your vision coverage, please contact Vision Member Services at **(877) 601-9083**, 8 a.m. to 5 p.m. Pacific time, Monday through Friday. Or visit **blueshieldcavision.com**.

Providers

To determine eligibility for Blue Shield members, call (800) 877-6372, or visit **www.mesvision.com/providers**.

MES Vision®

Blue Shield of California, an independent member of the Blue Shield Association ABU1576c-CA (4/16)

Submitting a claim

A claim form is not necessary when using a network provider. When using a non-network provider, the employer, employee and/or provider may be required to complete a Vision Claims form (C4669-61). Please refer to the claim form to determine which areas will need to be completed. Members may be expected to pay the full amount when using a non-network provider. They will be reimbursed after submitting a claim form.

Mail completed claim form(s) and documentation to:

Blue Shield of California
P.O. Box 25208
Santa Ana, CA 92799-5208

Manage your vision members online

Manage your vision members easily online using Employer Connection. Forms for administering group vision benefits can be printed from **blueshieldca.com** or ordered by contacting your Blue Shield account manager.

Vision Member Services

Vision Member Services can assist you with questions about eligibility or claims. For questions about your plan or renewal rates, please contact your broker or Blue Shield account manager.

Phone: **(877) 601-9083**
Fax: **(714) 619-4662**
Monday through Friday, 8 a.m. to 5 p.m. PST

Grievance process

Members, their providers, or attorney or representatives on behalf of members can contact our Vision Member Services representatives by telephone, online at **blueshieldca.com**, or by letter to request an initial review of a claim or service.

Vision Member Services can assist in completing the grievance form. Completed grievance forms must be mailed to the Vision Plan Administrator at:

Blue Shield
Vision Member Services
P.O. Box 25208
Santa Ana, CA 92799-5208

The Vision Plan Administrator will acknowledge receipt of a written grievance within five calendar days. Grievances are resolved within 30 days. The grievance system allows members to file grievances within 180 days following any incident or action that is the subject of the member's dissatisfaction.

Please note: If an employer's health plan is governed by the Employee Retirement Income Security Act ("ERISA"), employees may have the right to bring civil action under Section 502(a) of ERISA if all required reviews of a claim have been completed and a claim has not been approved.

Your vision plan is underwritten by Blue Shield of California or Blue Shield of California Life & Health Insurance Company and is administered by a vision plan administrator. Please refer to your *Evidence of Coverage* or *Certificate of Insurance* to identify which Blue Shield company underwrites your vision coverage.

How to manage your group life insurance benefits

Small business life insurance is available for groups of 2 to 100 eligible employees

We've designed the following section to make it easier for you to enroll and manage your group term life insurance plan.* By purchasing life insurance and accidental death & dismemberment (AD&D) insurance coverage along with your Blue Shield medical plan, you receive advantages of joint administration:

- Single enrollment form for both medical and life insurance
- Single point of contact for adding and deleting employees and dependents
- Combined billing statement for your medical and life insurance premiums

For non-contributory plans (employer pays 100% of the employee premium), 100% participation is required. For contributory plans (employer pays a portion of the employee premium), 65% participation is required.

Enrolling employees and dependents

All employees who are electing a Blue Shield medical plan and Blue Shield life insurance and AD&D coverage should complete a Blue Shield Employee Application, with the Life Insurance Beneficiary section completed. Employees waiving medical plan coverage should use the same application electing life only and complete the Life Insurance Beneficiary section. All completed applications should be submitted to the health plan billing representative. **Please note that you are responsible for maintaining beneficiary information.**

For contributory groups, employees who did not apply for coverage when they were first eligible or at the time of a qualifying event (birth, death, divorce, etc.) will be required to submit an Evidence of Insurability form (CP1021) and may be subject to medical underwriting in order to obtain coverage. This requirement applies even during the medical open enrollment period. Dependent coverage may be changed in the case of an interim special event (marriage, divorce, adoption or birth of a child) as long as the employee is already enrolled.

Employees must be actively at work and meet the eligibility requirements listed in the policy in order to be eligible for enrollment in life insurance. **Employees on Leave of Absence are not eligible to enroll in Life and/or AD&D insurance, even if they are eligible for medical and/or other products.**

Employee status change

You are responsible for maintaining accurate eligible employee information.

- You are responsible for maintaining copies of completed Employee Application and Beneficiary Change form (ABU1165).
- You provide the beneficiary designation forms directly to the Blue Shield life insurance claims department only when submitting a life insurance and AD&D insurance, or waiver of premium claim.
- You are responsible for maintaining Statements of Domestic Partnership, if applicable.
- You are responsible for notifying employees of their potential eligibility for:
  - Waiver of Premium upon total disability
  - Conversion upon termination of employment or reduction in coverage.

Counseling employees on naming beneficiaries

Employees may change their beneficiary at any time, as often as they wish, using Beneficiary Change form (ABU1165). You are responsible for maintaining your employee's current beneficiary information and providing it to Blue Shield Life in the event a Life Claim is filed.

- Due to California's community property laws, the spouse of a married employee is entitled to 50% of their life insurance proceeds. If your employee wishes to designate someone other than their spouse for more than 50% of their life insurance proceeds, the spouse must approve the designation by signing Beneficiary Change form (ABU1165).
- Due to California's Uniform Transfer to Minor's Act, a child under the age of 18 may not receive funds in excess of $10,000. In the event a minor is named as beneficiary of a life insurance policy, the funds would be held until the child reaches 18 years of age.

Invoice procedures

Membership changes should be faxed or mailed to Blue Shield Life to be reflected on the following month's invoice and Add/Change/Terminate Report. It is important to pay the amount shown on the invoice. Please do not subtract terminating employee's dues from the amount due as it will result in a negative balance on the next month's bill. Termination information should be submitted on the Employee Change Transmittal form (C3843). The amount will be credited on the next billing cycle.

Certificate of Insurance

- For groups with life insurance policies effective prior to January 1, 2017, *Certificates of Insurance* are automatically generated and mailed to each employee as they are enrolled under your policy.
- For group life insurance policies effective January 1, 2017 or later, a group specific certificate will be included with your group's policy. You should make this certificate available to your employees.
- Questions about Blue Shield Life Certificate of Group Insurance should be directed to your health plan billing representative, or Employer Services at **(800) 325-5166.**

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

How to submit a life and/or AD&D insurance claim

If your employee or an employee's eligible dependent dies, you are responsible for filing the claim with Blue Shield Life on behalf of your employee and/or their beneficiaries. Blue Shield Life works exclusively with Group Administrators when processing life insurance claims for group members and their dependents.

The following documents are required for a life insurance claim:

- Proof of Death claim form (ABU1180) signed by an authorized group contact
- Original Death Certificate. Photocopies and scanned versions are not acceptable.
- Proof of beneficiary designation, in one of the following formats:
  - The employee's original application
  - A Beneficiary Change Request form (ABU1165)
  - For dependent claims, the employee is the beneficiary.
- Proof of eligibility: Paycheck stubs showing the number of hours worked, for two months prior to the last day the employee reported to work.

The following additional documents are required for an accidental death claim:

- The official investigative report (i.e., police, accident, fire, FAA, OSHA)
- Autopsy report
- Toxicology report, and/or
- Any medical records requested by Blue Shield.

The following documents are required for a dismemberment claim:

- Dismemberment Claim form (ABU1181) completed by the employer, employee and attending physician.
- Proof of eligibility: Paycheck stubs showing the number of hours worked, for two months prior to the last day the employee worked, prior to the date of the accident.

If the beneficiary would like a portion of the proceeds paid to a funeral home, please submit the funeral home's assignment forms, signed by the beneficiary, along with the claim documents.

Mail claim form and documentation to:

Blue Shield Life
Specialty Benefits Operations
4203 Town Center Blvd.
El Dorado Hills, CA 95762

Once all of the required documents are submitted, it will take 10 - 15 days for processing. The check or explanation letter will be sent to you to be forwarded onto the beneficiaries. If the beneficiary is a minor, the proceeds will be held until the minor turns 18 years old.

Questions? Call **(888) 800-2742**, option 3.

How to submit a Waiver of Premium claim

If your employee becomes totally disabled before age 65 and is expected to remain so for a period of at least six months, they may be eligible for a waiver of premium. Proof of total and continuous disability must be received by Blue Shield no later than 12 months following the onset of disability (the last day worked) and no longer than six months after the group's life insurance policy terminates.

The following documents are required:

- Waiver of Premium claim form (ABU1182) completed by employer, employee and/or attending physician
- Proof of current beneficiary designation
- Paycheck stubs showing the number of hours the employee worked for the two months prior to the last day the employee reported to work

Once approved, life insurance coverage will remain in force until the earliest of the following:

- The subscriber is no longer disabled, or
- The subscriber has not provided suitable written proof of continued disability as required by us, or
- The subscriber refuses to be examined by a physician when required by us, or
- The subscriber attains an age or retirement status as specified in the contract.

Updated medical information is requested and reviewed on an annual basis; individual circumstances may result in fewer or more frequent reviews. Blue Shield will periodically contact the subscriber to verify their address and confirm they have not returned to work.

Waiver of Premium may be converted when the benefits are terminated, and at the subscriber's request. The application for conversion must be made within 60 days of termination of coverage. Only amounts $2,000 or higher are eligible for conversion.

Please refer to your plan policy for a complete description of conditions and limitations.

Mail Waiver of Premium claim form and documentation to:

Blue Shield Life
Specialty Benefits Operations
4203 Town Center Blvd.
El Dorado Hills, CA 95762

How to submit an accelerated death benefit (ADB) claim

If your employee becomes terminally ill before the age of 65 with 12 months or less to live, they may be eligible to withdraw an accelerated death benefit (ADB) benefit, subject to the following minimums and maximums:

- Maximum withdrawal allowed is 50% of benefit or $50,000, whichever is lower
- Minimum withdrawal allowed is 10% of benefit or $5,000, whichever is greater
- Minimum of $15,000 in group coverage is required to receive ADB

The following documents are required:

- An ADB claim form (ABU1139) completed by the employer, employee and/or attending physician.
- Paycheck stubs showing the number of hours the employee worked for the two months prior to the last day the employee reported to work.

Please refer to your plan policy for a complete description of conditions and limitations.

Mail ADB claim form and documentation to:

Blue Shield Life
Specialty Benefits Operations
4203 Town Center Blvd.
El Dorado Hills, CA 95762

How to convert from term life insurance to whole life insurance

All active employees covered under the group policy can convert to an individual whole life insurance policy if they lose their job, their benefits are reduced (due to age or a change in class), or if they are disabled.* All covered employees must be given the opportunity to request conversion information if their employment is terminated or their benefits are reduced. You should communicate this benefit to each employee.

The entire amount of group term life insurance coverage lost can be converted. Exceptions to conversion are as follows:

- Upon termination or amendment of the group policy, or
- The employee requested termination of the group life insurance or cancelled the payroll deduction for the life insurance, or
- As prohibited by state law.

When all or part of the employee's group life insurance or dependent life insurance terminates due to an amendment or termination of the group policy, a conversion to individual whole-life policy may be purchased without evidence of insurability if the employee and/or dependent has been covered continuously under the group policy for at least five years.

Group term life or dependent life coverage can be converted. Accidental death and dismemberment (AD&D) coverage does not qualify for conversion.

Applicants should complete and submit an Individual Conversion Life Insurance Policy application form (CP1020) within 60 days of the termination or benefit reduction in order to be eligible for the conversion policy. After 60 days, the application will be declined. Paycheck stubs showing the number of hours the employee worked for the two months prior to the last day the employee reported to work will also be required.

The premium will be greater than what was charged under the group plan, since group insurance is less expensive than individual insurance, and the employee will be billed individually for the coverage. Additionally, the coverage will change from term life to whole life. The premium rate is based on the age of the applicant and the amount being converted. Premium information can be found on page 3 of the Individual Conversion Life Insurance Policy application.

While the employee does not have to convert the full amount of their group coverage, it is not possible to apply for more than the amount in force under the group term life insurance policy and the amount cannot be less than $2,000. Additionally, if the employee becomes eligible for any group life insurance within 31 days after termination, the amount of the conversion policy may not exceed the amount of term life insurance which terminates, less the amount of the group life insurance for which the person becomes eligible.

Please refer to your plan policy for a complete description of conditions and limitations.

Mail the Individual Conversion Life Insurance Policy application form to:

Blue Shield Life
Specialty Benefits Operations
4203 Town Center Blvd.
El Dorado Hills, CA 95672

Forms

Forms for administering group life insurance are listed on page 46. You can print them from **blueshieldca.com** or order them by contacting your Blue Shield account manager.

For questions about your plan or new rates, please contact your Blue Shield account manager.

* If the employee meets the definition of "disabled" under the terms of the life insurance policy, they may be eligible for the Waiver of Premium benefit. If approved, the Waiver of Premium benefit would begin after the benefit's waiting period. While the group coverage remains in force, the group will not be billed for the coverage. Further, a subscriber may choose to apply for a Life Conversion if the employer terminates the subscriber's coverage before they are eligible (or approved) for Waiver of Premium or upon the termination of the Waiver of Premium benefit.

Grievance process

Members, their providers, or attorney or representatives on behalf of members can contact Member Services by telephone, online at **blueshieldca.com** or by letter to request an initial review of a claim or service. Blue Shield will collaborate to resolve the members' grievance within the required time frames.

Member Services can assist in completing the grievance form. Completed grievance forms must be mailed to the Life/AD&D Plan Administrator at the address below:

Blue Shield of California Life & Health Insurance Company
Appeals & Grievances
P.O. Box 5588
El Dorado Hills, CA 95762-0011

The Life/AD&D Plan Administrator will acknowledge receipt of a written grievance within five calendar days. Grievances are resolved within 30 days. The grievance system allows members to file grievances within 180 days following any incident or action that is the subject of the members' dissatisfaction.

Please note: If an employer's health plan is governed by the Employee Retirement Income Security Act ("ERISA"), employees may have the right to bring civil action under Section 502(a) of ERISA if all required reviews of a claim have been completed and a claim has not been approved.

Forms

To get more copies of any of the forms included in the Forms section or for any additional forms which you may need, you can go to **blueshieldca.com/employer**, under Reference Library, and click on *Forms*. If you need additional assistance, contact your broker or Blue Shield account manager.

Employer forms

Master Group Application (form C15385)	If you are purchasing or making a change/addition to a standalone vision plan (Vision Standard, Plus, or Deluxe plan), please use this Master Group Application.
Employer Notification of Qualifying Event Under Cal-COBRA (form C13140)	Cal-COBRA is for employers with 2 to 19 employees and is administered by Blue Shield. Use this form to give written notification to Blue Shield of a subscriber's termination or reduction of hours, within 30 days of the event.
Request for Contract Change (form C15782)	Use this form to submit open enrollment changes during the renewal period. If you are purchasing or making a change/addition to a standalone vision plan (Vision Standard, Plus, or Deluxe plan), please use a Master Group Application rather than a Contract Change Request.
Employee Change Transmittal (form C3843)	Each month, use this form to complete eligibility changes for every billing unit within the group. Note: We've included extra copies of this form in your Administrator Kit, so you can print or photocopy it and submit it to Blue Shield each month with any changes.
Employee Cancellation Transmittal Request (form A36965)	As a group contact, complete this form to submit information on employee terminations/cancellations.
Notice of Total and Permanent Disability (form C4424)	To file for an extension of benefits in the case of a total and permanent disability, you need to complete this form. In addition, employees must complete a Subscriber Statement of Disability.

Employee forms

Employee Application for Groups With 1 to 100 Employees (form C12914)	Employees need to complete the appropriate Employee Application. If employees decline enrollment in your group's health benefit plan, they must complete the Refusal of Personal Coverage section of the Employee Application.
Refusal of Coverage (form C19927)	Employees should use this form when they, their spouse, domestic partner, or dependent(s) are eligible but refusing your group coverage.
Subscriber Change Request (form C675-1) Subscriber change requests can be done online.	Enrolled employees must complete this form whenever they make status or coverage changes, such as adding or deleting dependents. Submit the form immediately and audit your bill in order to ensure that all applicable changes are reflected.
Group Continuation Coverage (COBRA) Election (form C11825-RTM)	When a qualified beneficiary elects to participate in COBRA, he or she must complete this form. **Note:** This form is for PPO members only.
HMO COBRA Application (form C12559-RTM)	If a qualified beneficiary elects to participate in COBRA, he or she must complete this application. **Note:** This form is for HMO members only.

Employee forms

Continuing Cal-COBRA under Blue Shield of California **Cal-COBRA Take-Over (form C14755)**	Employees should complete these forms to elect Blue Shield of California over Cal-COBRA coverage from a prior carrier. To get additional copies of forms for your employees, go to **blueshieldca.com/employer** and click on *Employee Forms*. You can then view, download and print any form.
Subscriber's Statement of Claim (form CLM-14850)	Employees should use this form when the provider of service does not submit its claims directly to Blue Shield. Employees must attach a copy of their itemized bill (which should be on the provider's letterhead or billing form) to this completed form, and send them to the service center address listed. Employees should complete this form only when the providers of service do not submit their claims directly to Blue Shield. This is for Blue Shield of California plans only.
Subscriber's Statement of Claim Blue Shield Life (form CLM-15481)	Employees should use this form when the provider of service does not submit its claims directly to Blue Shield of California Life & Health Insurance Company (Blue Shield Life). Employees must attach a copy of their itemized bill (which should be on the provider's letterhead or billing form) to this completed form, and send them to the service center address listed. Employees should complete this form only when the providers of service do not submit their claims directly to Blue Shield Life. This is for Blue Shield Life plans only.
Declaration of Disability for Over-Age Dependent Children (form C3674)	Employees should fill out this form to enroll a dependent who would normally have lost their eligibility solely due to age but who is disabled by reason of a physically or mentally disabling injury, illness, or condition.
Attending Physician Statement of Disability (form C4425)	To file for an extension of disability benefits, the employee's Personal Physician must complete and submit this form to Blue Shield. In addition, employees must complete a Subscriber Statement of Disability form and you must fill out a Notice of Total and Permanent Disability form.
Subscriber Statement of Disability (form C12198)	To file for an extension of disability benefits, employees must complete this form. In addition, you need to complete a Notice of Total and Permanent Disability.
Authorization to Disclose Personal & Health Information to a Third Party (form C15625)	Blue Shield requires specific written authorization for the disclosure of any personal and health information, beyond that which is necessary to provide treatment, to facilitate payment, or to perform operations of the health plan or insurer, to the extent permitted by law. Blue Shield will only disclose that information which is reasonably necessary to achieve the purpose of the request for release.
Dental Claim Form (form C11716)	Employees should complete this form to submit a dental claim for services received from a non-network provider.
Vision Claim Form (form C-4669-61)	Employees should complete this direct reimbursement form for vision care services received from a non-network provider.
Vision Plan Information Card ABU15756-CA (for California members) ABU15756-OOS (for members outside California)	The card is not required, but has useful information for both the member and the provider.

* If the employee meets the definition of "disabled" under the terms of the life insurance policy, they may be eligible for the Waiver of Premium benefit. If approved, the Waiver of Premium benefit would begin after the benefit's waiting period. While the group coverage remains in force, the group will not be billed for the coverage. Further, a subscriber may choose to apply for a Life Conversion if the employer terminates the subscriber's coverage before they are eligible (or approved) for Waiver of Premium or upon the termination of the Waiver of Premium benefit.

Employee forms

Life insurance forms	**Forms for administering group life insurance and/or AD&D insurance benefits are listed below. They can be easily downloaded and printed from blueshieldca.com, or ordered by contacting your Blue Shield account manager.**
Accelerated Death Benefit Claim (form ABU1139)	Employer, employee and/or attending physician will need to complete this form for insured persons to receive life benefit proceeds prior to their death. See plan benefits for eligibility provisions.
Life and AD&D Waiver of Premium Claim (form ABU1182)	Employer, employee and/or attending physician will need to complete this form for insured employees who become totally disabled before age 60 to continue their life coverage at no cost (i.e., waiving the premium). See plan benefits for eligibility provisions.
Life Insurance Proof of Death Claim (form ABU1180)	Employers should complete this form in the event an employee passes and submit it with the other required documents.
Conversion to Individual Policy from Group Life Insurance (form CP1020)	Employer and employee should complete this form when an employee loses their group term life coverage and they wish to convert it to individual whole life.
Life and AD&D Statement of Domestic Partnership (form C15388)	Employees should complete this form when they have additions, deletions and other changes to their coverage.
Life and AD&D Beneficiary Change Request (form ABU1165)	Employees should complete this form when they have additions, deletions and other changes to their coverage.

Where to send completed employee forms

Form name	Form number	Where to mail form	Where to fax form
HMO COBRA Application	C12559-RTM	Membership Eligibility Processing Unit Blue Shield of California P.O. Box 3008 Lodi, CA 95241-1912	**(855) 808-8598**
Group Continuation Coverage (COBRA) election	C11825-RTM		
Declaration of Disability for Over-Age Dependent Children	C3674		
Continuing Cal-COBRA under Blue Shield of California Cal-COBRA Take-Over	C14755	Blue Shield of California Cal-COBRA P.O. Box 629009 El Dorado Hills, CA 95762	**(916) 350-7480**
Subscriber's Statement of Claim Blue Shield Life	CLM-15481	Blue Shield of California P.O. Box 272610 Chico, CA 95927-2540	Claim forms must be mailed.
Subscriber's Statement of Claim	CLM-14850	Blue Shield of California P.O. Box 272540 Chico, CA 95927-2540	Claim forms must be mailed.
Employee Application	C12914	Membership Eligibility Processing Unit Blue Shield of California P.O. Box 3008 Lodi, CA 95241-1912	**(855) 808-8598** or email **small.group@blueshieldca.com**
Refusal of Coverage	C19927		
Subscriber Change Request	C675-1		
Employee Cancellation Transmittal Request	A36965		
Subscriber Statement of Disability	C12198	Blue Shield of California Program Management Office/Extension of Benefits 4203 Town Center Blvd. El Dorado Hills, CA 95762-9806	**(855) 808-8598**
Attending Physician Statement of Disability	C4425		
Authorization to Disclose Personal & Health Information to a Third Party	C15625	Blue Shield of California Attn: Customer Service P.O. Box 272540 Chico, CA 95927	Form must be mailed.
Dental, vision and life insurance forms	See forms at **blueshieldca.com** for instructions on where to submit.		

Where to send completed employer forms

Form name	Form number	Where to mail form	Where to fax form
Request for Contract Change	C15782	Membership Eligibility Processing Unit Blue Shield of California P.O. Box 3008 Lodi, CA 95241-1912	**(209) 367-6603** or email **small.group@blueshieldca.com**
Master Group Application	C15385	Membership Eligibility Processing Unit Blue Shield of California P.O. Box 3008 Lodi, CA 95241-1912	**(209) 367-6475** or email **small.group@blueshieldca.com**
Employee Change Transmittal	C3843	Membership Eligibility Processing Unit Blue Shield of California P.O. Box 3008 Lodi, CA 95241-1912	**(855) 808-8598** or email **small.group@blueshieldca.com**
Employer Notification of Qualifying Events Under Cal-COBRA	C13140	Blue Shield of California Cal-COBRA Administration P.O. Box 629009 El Dorado Hills, CA 95762-9009	**(916) 350-7480**
Continuing Group Coverage after Federal COBRA Cal-COBRA Election	C18157	Blue Shield of California Cal-COBRA Administration P.O. Box 629009 El Dorado Hills, CA 95762-9009	**(916) 350-7480**
Notice of Total and Permanent Disability	C4424	Blue Shield of California Program Management Office/Extension of Benefits 4203 Town Center Blvd. El Dorado Hills, CA 95762-9806	**(855) 808-8598**

To get additional copies of forms, go to **blueshieldca.com/employer**.

Blue Shield sales offices

Northern California

Fresno
5250 N. Palm Ave., Suite 120
Fresno, CA 93704
Toll-free: **(800) 779-1906**
Phone: **(559) 440-4000**
Fax: **(559) 436-0371**

Sacramento
4203 Town Center Blvd.
El Dorado Hills, CA 95762
Phone: **(916) 350-7324**
Fax: **(916) 350-8609**

San Francisco
50 Beale St.
San Francisco, CA 94105
Phone: **(415) 229-5272**
Fax: **(415) 229-6230**

Walnut Creek
2175 N. California Blvd., Suite 250
Walnut Creek, CA 94596
Toll-free: **(877) 685-2676**
Phone: **(925) 927-7400**
Fax: **(925) 927-7410**

Southern California

Los Angeles
100 N. Sepulveda Blvd.
El Segundo, CA 90245
Toll-free: **(800) 499-3899**
Phone: **(310) 744-2580**
Fax: **(310) 744-2680**

Ontario
3401 CentreLake Drive, Suite 400
Ontario, CA 91761
Toll-free: **(800) 628-6501**
Phone: **(909) 974-5200**
Fax: **(909) 974-5255**

Costa Mesa
555 Anton Blvd., Suite 800
Costa Mesa, CA 92626
Toll-free: **(800) 965-7587**
Phone: **(714) 428-4800**
Fax: **(877) 251-2230**

San Diego
2275 Rio Bonito Way, Suite 250
San Diego, CA 92108
Toll-free: **(877) 847-8851**
Phone: **(619) 686-4200**
Fax: **(619) 686-4250**

Woodland Hills
6300 Canoga Ave.
Woodland Hills, CA 91367
Toll-free: **(800) 804-7420**
Fax: **(818) 228-5206**