Managing your group coverage:
Membership claims and administration for groups with 101+ eligible employees
Welcome to Blue Shield

This guide provides you with all the information you need to quickly enroll your employees and manage your group benefits. Inside you’ll find a list of contacts, easy instructions on how to enroll your employees, useful information on programs and services, and fast answers on payments and processes.

Employees have access to some of the largest provider networks in California and a wealth of health management programs and top-notch customer support included with their health plan – all to make it easier for them to stay healthy.

If you have any questions, Blue Shield’s customer service representatives and your dedicated sales representative are standing by to help you get the job done. We look forward to serving you.
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## Contact information

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<td><strong>Core Priority client services</strong></td>
<td>Questions about group health plan eligibility, escalated issues and complex claims questions</td>
<td>Core Priority (855) 747-5809 or email by regions: 8 a.m. to 5 p.m. Pacific time, Monday – Thursday 9 a.m. to 5 p.m., Friday <a href="mailto:corepriority@blueshieldca.com">corepriority@blueshieldca.com</a></td>
</tr>
<tr>
<td><strong>Group billing representative</strong></td>
<td>Billing issues</td>
<td>Your group billing representative at the number on your billing statement, or by email: <a href="mailto:group.billing@blueshieldca.com">group.billing@blueshieldca.com</a></td>
</tr>
<tr>
<td><strong>Eligibility</strong></td>
<td>Employee enrollments, changes or cancellations</td>
<td>Processing requests: <a href="mailto:largegroup.membereligibility@blueshieldca.com">largegroup.membereligibility@blueshieldca.com</a></td>
</tr>
<tr>
<td><strong>Cal-COBRA administration</strong></td>
<td>Cal-COBRA eligibility, coverage, extensions and cancellations</td>
<td>Blue Shield of California Cal-COBRA (800) 228-9476 Fax: (916) 350-7480 9 a.m. to 5 p.m. Pacific time, Monday – Friday Blue Shield of California Cal-COBRA Administration P.O. Box 629009 El Dorado Hills, CA 95762-9009</td>
</tr>
<tr>
<td><strong>Employer-administered flexible spending account (FSA)</strong></td>
<td>Questions about FSA programs</td>
<td>HealthEquity (888) 382-3510 <a href="mailto:employerservices@healthequity.com">employerservices@healthequity.com</a></td>
</tr>
<tr>
<td><strong>Life/AD&amp;D</strong></td>
<td>Questions about claims, declined services or minor beneficiaries</td>
<td>(888) 800-2742 9 a.m. to 5 p.m. Pacific time, Monday – Friday</td>
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### For employees

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<td><strong>Shield Concierge</strong></td>
<td>Member assistance for Trio HMO members and a single source for answers from a team that includes registered nurses, health coaches, social workers, pharmacists, pharmacy technicians and customer services representatives.</td>
<td>Shield Concierge: (855) 829-3566</td>
</tr>
<tr>
<td><strong>Blue Shield of California Member Services</strong></td>
<td>Member assistance for Blue Shield health benefits and services. For language assistance, members can call the number on the back of their Blue Shield member ID card.</td>
<td>Blue Shield of California Member Services PPO members: (888) 256-1915</td>
</tr>
<tr>
<td><strong>Blue Shield of California HMO and POS (point-of-service) Member Services</strong></td>
<td>Member assistance for Blue Shield HMO or POS health benefits and services.</td>
<td>Blue Shield of California Member Services (888) 256-1915</td>
</tr>
<tr>
<td><strong>Blue Shield of California and Blue Shield of California Life &amp; Health Insurance Company – Member Services</strong></td>
<td>Member assistance for Blue Shield health benefits and services.</td>
<td>(888) 852-5346, or call the number listed on the employee’s Blue Shield ID card</td>
</tr>
<tr>
<td>Contact</td>
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<tr>
<td>Customer Service Life/AD&amp;D</td>
<td>Member assistance for Blue Shield specialty benefits and services.</td>
<td>(888) 800-2742 9 a.m. to 5 p.m. Pacific time, Monday – Friday</td>
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<tr>
<td>Hearing-impaired services</td>
<td>Member service information.</td>
<td>(TTY): (800) 241-1823</td>
</tr>
<tr>
<td>Blue Shield’s mental health service administrator (MHSA)</td>
<td>Claims process and benefit information for substance use disorder treatments and mental health benefits; and to get information about filing a claim.</td>
<td>HMO, PPO or POS members: (877) 263-9952 Blue Shield Life members: (877) 214-2928 Claims: (877) 263-9952</td>
</tr>
<tr>
<td>Pharmacy services – prior authorization requests and claims processing issues</td>
<td>Questions and information on drugs requiring prior authorization for medical necessity. Members should have their physician call this number to get prior authorization. Pharmacy representatives can assist pharmacies with processing of claims.</td>
<td>Call the number listed on the Blue Shield ID card</td>
</tr>
<tr>
<td>Mail service pharmacy</td>
<td>To order up to a 90-day supply of a covered maintenance drug for a chronic condition.</td>
<td>(866) 346-7200  (TTY): (866) 346-7197</td>
</tr>
<tr>
<td>Dental PPO and Dental HMO Claims and Benefit Inquiry</td>
<td>Member assistance for Blue Shield PPO dental benefits and services.</td>
<td>(888) 702-4171 5 a.m. to 5 p.m. Pacific time, Monday – Friday</td>
</tr>
<tr>
<td>Dental Member Services</td>
<td>Member assistance for Blue Shield dental plan eligibility, billing and account management.</td>
<td>(800) 325-5166 Fax: (877) 251-0889 5 a.m. to 5 p.m. Pacific time, Monday – Friday Blue Shield of California Installation &amp; Membership – Group P.O. Box 629014 El Dorado Hills, CA 95762-9014 Attention: Dental Eligibility Changes Email: <a href="mailto:LargeGroup.MemberEligibility@blueshieldca.com">LargeGroup.MemberEligibility@blueshieldca.com</a></td>
</tr>
<tr>
<td>Vision Claims and Benefit Inquiry</td>
<td>Blue Shield vision benefits and claims inquiries.</td>
<td>(877) 601-9083 8 a.m. to 5 p.m. Pacific time, Monday – Friday</td>
</tr>
<tr>
<td>Vision Member Services</td>
<td>Member assistance for Blue Shield vision plan eligibility, billing and account management.</td>
<td>(800) 325-5166 Fax: (877) 251-0889 5 a.m. to 5 p.m. Pacific time, Monday – Friday Blue Shield of California Installation &amp; Membership – Group P.O. Box 629014 El Dorado Hills, CA 95762-9014 Attention: Vision Eligibility Changes Email: <a href="mailto:LargeGroup.MemberEligibility@blueshieldca.com">LargeGroup.MemberEligibility@blueshieldca.com</a></td>
</tr>
<tr>
<td>Discount Vision Program</td>
<td>Members have access to discounted eye exams, eyewear and LASIK surgery with participating providers.</td>
<td>(800) 877-7195 5 a.m. to 7 p.m. Pacific time, Monday – Friday 6 a.m. to 2:30 p.m. Pacific time, Saturday</td>
</tr>
<tr>
<td>Find a Doctor – Customer Service</td>
<td>To find a primary care provider or specialist.</td>
<td>Call the number listed on the Blue Shield ID card or blueshieldca.com/fad</td>
</tr>
<tr>
<td>American Specialty Health Plans (ASH Plans) for HMO members</td>
<td>Questions about chiropractic and acupuncture benefits and services.</td>
<td>(800) 678-9133</td>
</tr>
<tr>
<td>Alternative Care Discount Program, American Specialty Health Plans (ASH Plans)</td>
<td>Questions about discounts on chiropractic, acupuncture and massage services and to find a provider.</td>
<td>(888) 999-9452 5 a.m. to 6 p.m. Pacific time, Monday – Friday</td>
</tr>
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Blueshieldca.com

Whether you want to download a claim form or learn about the available health management programs, blueshieldca.com offers you easy, 24-hour access to the information you need to help you and your employees take control of their healthcare coverage.

Employer Connection
Finding information is simple. Just go to blueshieldca.com/employer and select Register Now to get started. Visit blueshieldca.com/ecp-getting-started to see the library of quick demos on the various features of Employer Connection.

Once registered, you’ll be able to:
• Make real-time member updates, such as adding or terminating coverage
• Manage your group’s medical, dental, vision and life insurance plans
• Make one-time payments or set up automatic payments
• Download and review current and past Blue Shield invoices
• Order Blue Shield medical member ID cards
• Enter your employees’ open enrollment selections upon renewal
• Create/manage additional users for your Employer Connection account
• Create and download census and billing reports

Blue Shield plans
Get updated plan overviews for medical, dental, vision and life insurance plans, and learn about flexible spending accounts (FSAs) and Premium Only Plans (POPs).

Knowledge Center
Explore this hub for news, articles and reference information about healthcare and insurance industry topics of interest, especially for California employers.

Administrator resources
Managing your healthcare coverage doesn’t have to be a hassle. At Blue Shield we are continually working to bring you the information you need, quickly and efficiently.

In this section, you’ll find reference materials and resources for electronic enrollment, online maintenance, employee wellness programs and more.

Why Blue Shield?
Discover our advantages, including large provider networks, plan flexibility and choice, wellness programs, and strong industry leadership.
Member Center

When your employees come to you with questions about their health coverage, you can refer them to our website, blueshieldca.com, to view their confidential health plan information. Online registration is simple and secure – employees choose a username and password, and their personal information will be encrypted to ensure privacy. The online Member Center allows members to manage their entire family’s plan, including benefits, primary care physician (PCP) and claims information under one user profile. Employees can also find answers to their questions by reading their Evidence of Coverage or Certificate of Insurance, located in the back of their member guide.

Plus, employees can easily access resources at blueshieldca.com that help them improve their health and better manage their costs.

When they log in, they can:

• See highlights and details of their medical coverage and information about their dental and vision plans
• Access copayment and deductible amounts
• Check the status of claims for the whole family
• Set up claims alerts and paperless delivery of Eligibility of Benefits (EOB) statements
• Order replacement ID cards
• Print temporary ID cards
• Download forms
Find a Doctor

- Select your plan and search for a doctor, Independent Practice Association (IPA) or medical group, hospital, dentist, pharmacy, vision care, or alternative care practitioner.

- Print a personalized provider directory.

- Compare hospitals and IPA/medical groups, and individual PPO physicians according to quality indicators.

Pharmacy

- Search for a list of formulary drugs and find generic alternatives using the Plus Drug Formulary.

- Check for drug interactions and find information about medications.

- Refill maintenance prescriptions through the mail.

- Find a network pharmacy.
Wellvolution

Well-Being Assessment
Complete a short questionnaire and receive a confidential, personalized report of your overall well-being including ways you can improve your health.

Daily Challenge
With Daily Challenge®, you will receive a daily email that includes suggestions for simple and fun wellness-related tasks that can help improve your well-being.

QuitNet
Get the help you need to quit smoking with encouragement and support from the largest quit-smoking community in the world. QuitNet® now includes nicotine replacement therapy (NRT) at no additional cost.

Walkadoo
Walkadoo® is a wellness program for every walk of life. Make a move toward better health by using your smartphone to receive your daily step goals and count your steps – or bring your own step tracker.

Diabetes Prevention Program (DPP)
The Diabetes Prevention Program can help you lose weight, adopt healthier habits and reduce your risk of developing type 2 diabetes. It’s available at no cost to members who qualify. Find out more at solera4me.com/shield.

Wellvolution Trio HMO package
Trio plans include, for subscribers age 18 and older, core services to help live healthier lives. These services include helping employees measure their well-being, addressing specific areas of concern and engaging in purposeful, daily activities.

Package features include:
• Walkadoo – with activity tracking device
• Well-Being Assessment
• Daily Challenge
• QuitNet

Members in Trio HMO plans can receive a Fitbit® activity tracker at no charge when they sign up for Wellvolution®. Visit mywellvolution.com.
Health and wellness resources
These programs can help members take control of their health care and get the most value from their coverage. The programs don’t require any administration on your part, and are available at no extra cost to either you or your employees. Please encourage your employees to use these valuable resources.

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<td>NurseHelp 24/7℠</td>
<td>Call (877) 304-0504, 24 hours a day, seven days a week. TTY: (800) 855-2881.</td>
</tr>
<tr>
<td>Registered nurses can give members immediate answers and reliable information about:</td>
<td>Or, log in to blueshieldca.com and click on Be Well.</td>
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<td>• Minor illnesses and injuries</td>
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<td>• Chronic conditions</td>
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<td>• Medical tests and medications</td>
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<td>• Preventive care</td>
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<tr>
<td>LifeReferrals 24/7℠</td>
<td>Call (800) 985-2405, 24 hours a day, seven days a week. TTY: (800) 855-2881.</td>
</tr>
<tr>
<td>Members can speak confidentially with a team of experienced professionals* on a wide variety of topics including:</td>
<td>Or, log in to blueshieldca.com and click on Be Well.</td>
</tr>
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<td>• Personal issues like relationship problems and grief</td>
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<tr>
<td>• Legal and financial questions</td>
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<tr>
<td>• Child and elder care issues or referrals</td>
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<td>Wellvolution</td>
<td>Members can visit mywellvolution.com to register.</td>
</tr>
<tr>
<td>Ready for a wellness program with a unique approach? Wellvolution programs offer healthy encouragement, realistic goals and enjoyable social connections that can be easily worked into even the busiest lifestyles.</td>
<td>Go to blueshieldca.com and click on Be Well.</td>
</tr>
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<td>Decision support tools</td>
<td>Go to blueshieldca.com, click on Be Well, then Health Topics, then Health Conditions. Or call (877) 455-6777 for care management, (866) 954-4567 for health management programs or (877) 371-1511 for Prenatal Education.</td>
</tr>
<tr>
<td>Access online tools to help you compare hospitals, explore treatment options for your condition and learn more about prescription drugs.</td>
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<td>Shield Support care and health management programs</td>
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<td>Shield Support encompasses a broad spectrum of interventions for short-term care coordination as well as ongoing case management for acute, long-term and high-risk medical conditions. Health management programs support self-care for members living with chronic conditions such as asthma, diabetes, chronic obstructive pulmonary disease (COPD) and heart failure. Blue Shield also offers programs that support and educate members about pregnancy, childbirth and newborns. Members are contacted once identified and they can enroll online.</td>
<td>Go to blueshieldca.com, click on Be Well, then Health Topics, then Health Conditions. Or call (877) 455-6777 for care management, (866) 954-4567 for health management programs or (877) 371-1511 for Prenatal Education.</td>
</tr>
</tbody>
</table>

* All services are confidential. Some services may not be available to all Blue Shield members; check your group plan Evidence of Coverage to see what it offers. Referrals to community resources are available for no extra cost, but any costs associated with using these resources are the responsibility of the member. NurseHelp 24/7 and LifeReferrals 24/7 are designed to complement, not replace, their care.

NurseHelp 24/7 and LifeReferrals 24/7 are service marks of Blue Shield of California.
<table>
<thead>
<tr>
<th>Resource</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wellness discount programs</strong> – Cost-saving options available to members:</td>
<td>Members may visit blueshieldca.com/wellnessdiscounts for more information.</td>
</tr>
<tr>
<td><strong>Weight Watchers</strong> – Members enjoy a wide range of savings, including online subscriptions, at-home kits and local meeting monthly pass discounts.</td>
<td></td>
</tr>
<tr>
<td><strong>24 Hour Fitness</strong> – To help them get or stay fit, members receive waived enrollment, initiation and processing fees, and discounted monthly dues (amounts may vary by location).</td>
<td></td>
</tr>
<tr>
<td><strong>ClubSport and Renaissance ClubSport</strong> – Increase your wellness with savings options on membership dues and fees as well as on-site amenities.</td>
<td></td>
</tr>
<tr>
<td><strong>Alternative Care Discount Program</strong> – Provides up to 25% off the usual and customary fees from participating acupuncture, chiropractic and massage therapy practitioners, and online discounts off the suggested manufacturer’s retail price on a broad selection of quality health and wellness products, with free shipping on most items.</td>
<td></td>
</tr>
<tr>
<td><strong>Vision services</strong> – All Blue Shield members can save 20% on the following services and materials at participating providers, whether or not you have vision care benefits through Blue Shield. Access participating providers on the Find a Doctor page at blueshieldca.com/fad.</td>
<td></td>
</tr>
<tr>
<td>• Routine eye exams</td>
<td>• Extra pair of glasses</td>
</tr>
<tr>
<td>• Frames and lenses (including photochromic)</td>
<td>• Non-prescription sunglasses</td>
</tr>
<tr>
<td>• Tints and coatings</td>
<td>• Hard contact lenses</td>
</tr>
<tr>
<td><strong>Hearing Aid Discount</strong> – Available through EPIC Hearing Service, members have access to one of the largest networks of hearing care professionals in the country; 30%-60% savings off manufacturers' suggested retail price on major brands.</td>
<td></td>
</tr>
</tbody>
</table>

* These discount program services are not covered benefits of Blue Shield health plans, and none of the terms or conditions of Blue Shield health plans apply. Discount program services are available to all members with a Blue Shield medical, dental, vision or life insurance plan.

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 plan covered benefits. Members should access those covered services prior to using the discount program.

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

Discount programs are administered by or arranged through the following independent companies:
- Alternative Care Discount Program – American Specialty Health Systems, Inc. and American Specialty Health Group, Inc.
- Discount Provider Network and MESVisionOptics.com – MESVision
- Weight control – Weight Watchers North America
- Fitness facilities – 24 Hour Fitness, ClubSport, and Renaissance ClubSport
- LASIK – Laser Eye Care of California, LLC; QualSight, Inc.; and NVISION Laser Eye Centers

Note: No genetic information, including family medical history, is gathered, shared or used from these programs.

The Discount Provider Network is available throughout California. Coverage in other states may be limited.
<table>
<thead>
<tr>
<th>Resource</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>MESVision Optics</td>
<td>Members can visit blueshieldca.com/wellnessdiscounts for more information.</td>
</tr>
<tr>
<td>MESVisionOptics.com features competitive prices on many contact lens brands as well as a selection of sunglasses, reading glasses and eye care accessories.</td>
<td></td>
</tr>
<tr>
<td>Anyone can order discounted contact lenses, sunglasses, readers and accessories. Blue Shield vision plan members can apply their eligible benefits to reduce their out-of-pocket cost for contact lenses.</td>
<td></td>
</tr>
<tr>
<td>MESVision Optics stocks all major brands and types of contact lenses at a reduced price from other online retail sellers.</td>
<td></td>
</tr>
<tr>
<td>Every lens is shipped in a safe, sealed container and is guaranteed to be the exact lens prescribed by your doctor.</td>
<td></td>
</tr>
<tr>
<td>Free shipping is available for all orders over $50.</td>
<td></td>
</tr>
<tr>
<td>QualSight LASIK</td>
<td>Save on LASIK surgery at more than 45 surgery centers in California.</td>
</tr>
<tr>
<td>Members in California saved an average of $1,200 per LASIK surgery and over $800 on procedures such as Custom Bladeless (all-laser) LASIK in 2012.</td>
<td></td>
</tr>
<tr>
<td>Services include pre-screening, a pre-operative exam and post-operative visits.</td>
<td></td>
</tr>
<tr>
<td>Call (877) 437-6110 to find out if you are a potential candidate for this life-changing procedure today or visit <a href="http://www.qualsgight.com/lasikca">www.qualsgight.com/lasikca</a>.</td>
<td></td>
</tr>
<tr>
<td>NVISION Laser Eye Centers</td>
<td>As a Blue Shield of California member, you are entitled to a 15% discount from NVISION Laser Eye Centers.</td>
</tr>
<tr>
<td>NVISION Laser Eye Centers has some of the most experienced surgeons in the world, with offices in Southern California and Sacramento.</td>
<td></td>
</tr>
<tr>
<td>Use your flexible spending account or ask about affordable financing options.</td>
<td></td>
</tr>
<tr>
<td>Call NVISION at (877) 91 NVISION, or (877) 916-8474, or visit <a href="http://www.NVISIONcenters.com">www.NVISIONcenters.com</a> to find a provider or learn more about whether LASIK is right for you.</td>
<td></td>
</tr>
</tbody>
</table>

* Requires a prescription from your doctor or licensed optical professional.
Sometimes you can't wait for a doctor's visit. **So many options for care:**

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

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

**Primary care physician (PCP) $$$$**
Your main healthcare provider for routine medical needs.

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

**Heal™ $$$$**
On-demand physician house calls to your house, office or hotel.

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

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

**BlueCard® $$$$**
Access to covered services when you and your family are away from home.

**Emergency room $$$$**
Immediate care for emergencies.

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

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

If you are experiencing an emergency, call 911 immediately.
Get the care you need
As a Blue Shield member, you have many different care options available to you.*

### Providers available to all Blue Shield members:

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

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

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

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

NurseHelp 24/7 is a service mark of Blue Shield of California. Blue Shield and the Shield symbol are registered trademarks of the BlueCross BlueShield Association, an association of independent Blue Cross and Blue Shield plans.
Electronic enrollment options

To help make it easy for you to enroll employees and make enrollment changes quickly, Blue Shield offers several electronic options to simplify your administrative work.

Direct submission with optional Employer Connection Plus access

Blue Shield allows employers or their third-party benefits administrator (TPA) to electronically submit enrollment data directly to Blue Shield at no extra charge. Direct submission is typically a good solution for employers who:

- Use a human resource information system (HRIS) to manage employee enrollment data
- Already use the services of a Web-based benefits enrollment vendor

To get started with direct electronic submission, your group simply needs:

- Enrollment data in one of our many acceptable file formats, including ANSI 834
- Electronic file transmission capabilities through SFTP (secure file transfer protocol)
- Ability to submit files early in the enrollment process
- A technical and human resources point of contact for Blue Shield

How to set up an SFTP connection

For employers (and vendors) who would like to set up an SFTP connection, please complete and submit the Trading Partner Form for Inbound Enrollment below. If you have questions about completing this form, please contact the Electronic Enrollment team at Esquared@blueshieldca.com.


SFTP FAQ: blueshieldca.com/employerdocuments/administrator-resources/SFTPFAQGlossary.pdf

Employer Connection

As a complement to your direct submission method, Blue Shield offers secure online account-viewing capabilities via Employer Connection, which can be helpful for:

- Viewing Blue Shield’s source system to verify transmissions from your HRIS
- Conducting audits and/or reconciling your bill
- Obtaining employee listing by subscriber number
- Viewing plan benefit details, including eligibility rules and covered services, specific to your plan(s)

Once your direct submission method has been implemented, the primary contact for your organization can request access by easily registering online. Click Register Now on the Employer Connection home page to get started.

Once activated, your group’s primary contact can then grant Employer Connection access rights to others within your organization, or even to your broker or TPA.
Get started: Eligibility and enrollment

Eligibility requirements at a glance

Keep this helpful overview of eligibility requirements at your desk by printing this page.

The following chart represents standard provisions of your Group Health Service Contract or Policy. Please review your Group Health Service Contract or Policy for specific requirements on your group’s coverage.

<table>
<thead>
<tr>
<th>Type of enrollee</th>
<th>Requirements</th>
</tr>
</thead>
</table>
| Employee – permanent, year-round, full-time | • Works at least 30 hours per week  
• Performs job duties at your company’s usual place of business |
| Employee – part-time                    | • Works 20 to 30 hours per week                                                                   |
| Employee – temporary                    | Not eligible for Blue Shield group coverage unless your Group Health Service Contract or Policy includes a special provision extending coverage to them. |
| Sole owner or partner of a partnership  | • Full-time employee  
• Works at least 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 under age 26* or older if disabled. |
| 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:  
• 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 plan that’s right for them, they can apply directly to Blue Shield for health coverage through an Individual and Family Plan.  
Please contact your Blue Shield sales representative for more information. |

* The Patient Protection and Affordable Care Act redefined dependent children as of September 23, 2010 (for employer-sponsored plans, the later of September 23, 2010, or the first plan renewal date thereafter).
Eligibility requirements

This section covers basic eligibility requirements for employees and their dependents. Eligibility limitations may vary among groups, so please consult your Evidence of Coverage, Group Health Service Contract, Group Policy or Certificate of Insurance, or contact your Blue Shield sales representative for special provisions related to your company.

Employee eligibility
The three employee categories described below will help you determine an employee’s eligibility for coverage in a Blue Shield health plan.

Full-time employees
A full-time employee is eligible for coverage if he or she:
• Works at least 30 hours per week (this number may vary depending on your company’s personnel policy)
• Receives wages, commissions or a salary
• Performs job duties at your company’s usual place of business, unless the job requires traveling

A new full-time employee is eligible for coverage once the employee completes your company’s new-hire eligibility waiting period.

Part-time and temporary employees
An employee working fewer than the weekly hours necessary to qualify for full-time status is considered part time. Part-time, seasonal and temporary employees are not eligible for coverage unless your Group Health Service Contract or Policy includes a special provision extending coverage to them.

Part-time or temporary employees who become regular full-time employees are eligible for Blue Shield group coverage once they complete the company’s new-hire waiting period.

Rehired employees
A former employee who is rehired is eligible for coverage on the rehire date if the individual completed your company’s eligibility waiting period during the prior employment period and meets one of the conditions below. He or she:
• Resumed active employment within six months of loss of coverage with your company
• Terminated during the prior employment period to enter the armed forces, and resumed active employment within the time outlined by the law
• 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 is required to complete your company’s new-hire eligibility waiting period.

Please note: Reemployment notification must be indicated on the rehired individual’s employee application.
Dependent eligibility

This section covers eligibility requirements for five categories of dependents.

Spouses
An employee’s legally married spouse is eligible for dependent coverage if he or she is not legally separated from the employee.

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 employers 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 sex, with one exception: Opposite-sex partners are allowed if one partner is at least age 62 and eligible for Social Security.

2. Broad coverage: California state registration is not required, and the partners may be the same or opposite sex.

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 to be filed with the state of California or any other declaration or affidavit of domestic partnership.

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 age 26, or older if disabled (see following information for disabled over-age dependent children)

If your company employs both parents, their children may be covered as dependents of either parent, but not both.
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, Evidence of Coverage or 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 a written certification of the disability to Blue Shield at all of the following times:

- Within 60 days from the date of the employer’s or Blue Shield’s request; and
- Within 24 months after the child’s coverage would have ended, then annually thereafter

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

Qualified Medical Child Support Order (QMCSO)
A dependent child who is ordered to have coverage by the court cannot be denied because 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 of California HMO service area.

If the parent fails to apply to obtain 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 the employee’s court orders. If the employee is not currently enrolled, he or she needs to complete an Employee Application.
Access to care outside California

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

**The Blue Shield Global Core program**

For Blue Shield HMO and POS members

Blue Shield Global Core provides members and their covered dependents with 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 California.

For Smart Shield PPO, Shield Savings Plus and Active Choice® members

Blue Shield Global Core provides members and their covered dependents with access to medical care throughout the United States and worldwide.

Your health plan’s Evidence of Coverage or Certificate of Insurance describes member eligibility for the program. If your employees have questions about Blue Shield Global Core, please direct them to their member guides for a step-by-step process on how to use their Blue Shield Global Core program 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-Blue Shield Global Core program provider may be subject to higher out-of-pocket costs.

**Away From Home Care program for HMO members**

The Away From Home Care® program provides access to care for Trio HMO and Access+ HMO* members and their covered dependents if they are:

- Long-term travelers who leave 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 California.

Note: A child subject to a court order can take advantage of Away From Home Care, but is not required to do so.

- Students who are an employee’s dependents, attend school and live outside the HMO service area, but whose principal residence is the employee’s permanent residence.

Members can speak with a customer service representative about the Away From Home Care program by calling (800) 622-9402.

Please note these program restrictions

Away From Home Care benefits coverage will not extend beyond your group contract’s effective date. Program coverage is not automatic; it must be renewed annually.

To receive benefit coverage, members or their dependents must live in a service area offering Away From Home Care coverage.

Members using Away From Home Care services outside California will receive the benefits offered in the service area they are visiting.

Blue Shield Global Core provides members and their covered dependents with worldwide access to care.

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

Access+ HMO is a registered trademark of Blue Shield of California.
Ineligible individuals

These individuals are not eligible for Blue Shield group coverage:

• Parents, siblings, nieces or nephews of employees, or their spouses or domestic partners
• Foster children and grandchildren who are not legally adopted or for whom legal guardianship has not been established

Ineligible individuals for HMO/POS plans only:

• Dependents living and working outside of a Blue Shield HMO service area who do not meet the Away From Home Care program requirements*
• Students living and attending school outside of Blue Shield’s HMO service area who do not meet the program requirements*

Your employees who are ineligible for group coverage can apply for health coverage through a Blue Shield Individual and Family Plan. Contact your Blue Shield sales representative for more information.

* Does not apply to members with Qualified Medical Child Support Order (QMCSO).
Enrollment procedures

Keep this helpful overview of enrollment procedures at your desk by printing this page.

The following chart represents standard provisions of the Group Health Service Contract. Please review your Group Health Service Contract for specific requirements for your group’s coverage.

### Quick reference guide for enrollment procedures

<table>
<thead>
<tr>
<th>Enrollee</th>
<th>Eligibility date</th>
<th>Time to report</th>
<th>Documents required</th>
</tr>
</thead>
<tbody>
<tr>
<td>New employees and their dependents</td>
<td>The first billing date after the new employee completes your group’s waiting period</td>
<td>Within 31 days of the employee’s eligibility date</td>
<td>Employee Application; Eligibility Change Transmittal; or Self-Reporting Group Subscriber Report</td>
</tr>
<tr>
<td>Current employees transferring from one health plan to another</td>
<td>Effective date of your group’s open enrollment provision</td>
<td>Open enrollment</td>
<td>Subscriber Change Request; Eligibility Change Transmittal; or Self-Reporting Group Subscriber Report</td>
</tr>
<tr>
<td>Employees or dependents who lose other group, Medi-Cal or Healthy Families coverage</td>
<td>The date the employee or dependent loses the other group coverage</td>
<td>Within 31 days after the employee or dependent loses the other group coverage</td>
<td>The individual’s Refusal of Personal Coverage section of the Employee Application; written evidence of loss of coverage; Employee Application; Subscriber Change Request (for dependents only); Eligibility Change Transmittal; or Self-Reporting Group Subscriber Report</td>
</tr>
<tr>
<td>Rehired employees</td>
<td>If rehired within six months, effective date of rehire; If rehired after six months have elapsed, effective the first billing date after the employee completes your group’s waiting period</td>
<td>Within 31 days of the employee’s eligibility date</td>
<td>Employee Application; Eligibility Change Transmittal; or Self-Reporting Group Subscriber Report</td>
</tr>
<tr>
<td>Spouses</td>
<td>The date of marriage; or the date they lost their other group coverage</td>
<td>Within 31 days after the marriage; or within 31 days after the loss of their other group coverage</td>
<td>Employee Application; Eligibility Change Transmittal; or Self-Reporting Group Subscriber Report</td>
</tr>
<tr>
<td>Domestic partners</td>
<td>The date of partnership; or the date they lost their other group coverage</td>
<td>Within 31 days after partnership is declared; or within 31 days after the loss of their other group coverage</td>
<td>Employee Application; Eligibility Change Transmittal; or Self-Reporting Group Subscriber Report</td>
</tr>
<tr>
<td>Newborns</td>
<td>The date of birth</td>
<td>Within 31 days of birth</td>
<td>Employee Application; Eligibility Change Transmittal; or Self-Reporting Group Subscriber Report</td>
</tr>
<tr>
<td>Adopted dependents</td>
<td>The date the employee, spouse or domestic partner has the right to control the child’s health care</td>
<td>Within 31 days of the date the employee, spouse or domestic partner has the right to control the child’s health care</td>
<td>Written proof of the right to control the health care of the child, such as a medical authorization form; a health facility minor release form, or a relinquishment form; Employee Application; Eligibility Change Transmittal; or Self-Reporting Group Subscriber Report</td>
</tr>
<tr>
<td>Dependents subject to a court order for medical support</td>
<td>The date the court order is issued (or the date specified in the court order)</td>
<td>Earliest possible date</td>
<td>A copy of the court order; Employee Application; Eligibility Change Transmittal; or Self-Reporting Group Subscriber Report</td>
</tr>
</tbody>
</table>
Here’s a guide to help you easily understand the enrollment process so it goes smoothly for you and your employees.

**Annual open enrollment**

**What is open enrollment?**

Open enrollment is a window of at least 30 days for the employee to select their medical, dental and vision benefits. You can arrange a benefit meeting to review the plan benefit offerings and value-added programs, and to help answer employee questions. Open enrollment should be at least 30 days in duration and conclude no later than 10 working days prior to the groups’ effective renewal date of coverage.

You may contact your Blue Shield sales representative to help you coordinate the meeting. However, open enrollment benefit meetings are not mandatory.

**During this time:**

- An employee, who originally refused coverage, can now enroll
- An employee can add dependents who originally refused coverage
- An employee and their dependents may enroll in 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)

**What do employees need to complete during open enrollment?**

All open enrollment changes can be completed online using Employer Connection.

If a currently enrolled employee does not wish to make a change to their Blue Shield coverage, they do not have to do anything.

If the employee decides to make a plan change, or add or delete dependents, log in to blueshieldca.com/employer, find the employee in the member roster, select the employee, and select Update Subscriber Group to begin making changes.

An alternative way to make open enrollment changes is to complete paper forms. The employee will have to complete a Subscriber Change Request form. Additional forms may be required depending on the circumstance. For example, if the employee has disabled children, they will need to submit a Declaration of Disability for Over-Age Dependent Children form (C3674) or Refusal or Cancellation of Personal Coverage form (C13124) if the dependent is over-age or on a medical leave from a college or trade school.

For open enrollment information on:

- Dental coverage, see page 46
- Vision coverage, see page 49

If an existing employee who previously refused coverage decides to enroll in a Blue Shield plan, they will need to fill out an Employee Application.

Please note: Spouses/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, you should:

- Discuss the open enrollment coverage options with the employee before the open enrollment period; or
- If this is not possible and you know that the employee wants to transfer from one group plan to another, submit the employee’s application and note that the employee is unavailable.

Please note: If an employee who enrolls in Blue Shield’s Access+ HMO doesn’t choose a primary care physician during the open enrollment period, Blue Shield will indicate the assigned provider on the ID card, which will remain in effect until the employee chooses a different primary care physician.
Adding dependents

To add a dependent (i.e., newborn child, a spouse or an adopted child), you can easily add the dependent on Employer Connection. Simply log in at blueshieldca.com/employer, select the member from the member roster and select Update Dependent Status. Then follow the steps online to add a new dependent.

Another way to add a dependent is to have the employee complete and submit the paper version of the Subscriber Change Request form. Please make sure that HMO and POS members select a primary care physician for each dependent.

To add a newborn child, employees must complete and submit the Subscriber Change Request form within 31 days from the child's date of birth. For the first 31 days, HMO members must select a primary care physician for the child who is with the same IPA or medical group as the mother’s PCP. After 31 days, the newborn child will be considered a late enrollee. (See page 30 for more information on late enrollment.)

To add a child placed for adoption, employees must complete and submit the Subscriber Request form with documentation that the adopting parents have the right to control the child’s health care. The date that the parents have the right to control the child’s health care will be the effective date of coverage if the documents are submitted within 31 days of this date.

After the employee completes, signs and dates the Subscriber Change Request form, you must complete these five steps:

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. List the employee’s name and Social Security number (or any other identification number) on the Eligibility Change Transmittal or the Self-Reporting Group Subscriber Report.
5. Mail or fax the Subscriber Change Request form and the Eligibility Change Transmittal (or the Self-Reporting Group Subscriber Report) to the address listed in the appendix.

Selecting a primary care physician (HMO and POS plans only)

This step determines which doctor will coordinate all healthcare needs for your employees, with the exception of mental health and substance use disorder services.

Your employee must select a PCP who is located near his or her home or work address for reasonable access to care. However, each of the employee’s dependents may choose his or her own PCP.

Blue Shield will designate a PCP for employees or dependents who:

- Do not select a PCP when they enroll in a Blue Shield Access+ HMO or POS plan
- Select a doctor who is not a participating physician in the Access+ HMO provider network
- Choose a specialist who is not also a PCP
- 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

Blue Shield will notify the member of the designated PCP, which will remain in effect until the member chooses a different PCP. Your employees can reference their member guides for step-by-step instructions about how to select a PCP.

You can print out a personalized Blue Shield physician and hospital directory to give to your employees. The directory lists the locations and telephone numbers of physicians and hospitals within the Blue Shield provider network in the selected geographic area.

To print a directory, go to blueshieldca.com, click on Employer, then select Order Printed Materials under Employer Forms, followed by Customized Provider Directories. You can then personalize each directory based on plan type, and the directory will be available to you within minutes. Or, members can call the phone number on their ID card to request a directory.
Member ID cards

The member ID card identifies your employee as a Blue Shield member. If you offer dental HMO or dental PPO coverage, a separate ID card will be issued. Your employees should carry their Blue Shield ID cards with them at all times.

To order additional cards, you can do so on Employer Connection by selecting Order ID Cards on the Member Information page. Additionally, the member can order a card or print a temporary ID. They can log in to blueshieldca.com, click on My Health Plan or View Plan Summary and then select Order Blue Shield ID Cards, or call the number on their Blue Shield ID card. If they lost their card, they can call Member Services. Please see the “Contact information” section on page 8.

Trio HMO ID card sample

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HMO ID card sample

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PPO ID card sample

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**Note:** Top message states that the member should carry their Blue Shield ID cards with them at all times.
Blue Shield will issue a combination medical and prescription drug ID card to members within two weeks after they enroll in your Blue Shield group plan.
Evidence of Coverage or Certificate of Insurance

Your Evidence of Coverage (EOC) or Certificate of Insurance (COI) is the official Blue Shield document that describes the benefits, copayments, exclusions and limitations of your employees’ plan.

Shortly after the plan effective date, electronic versions will be distributed via Blue Shield’s employer website. Blue Shield will notify you by email when the EOC and/or COI are ready for distribution. You are responsible for distributing these documents, using one of the following ways:

- Post the documents on your company’s intranet for employee access.
- Email the documents directly to your employees.
- Provide your employees with instructions from Blue Shield on how to retrieve the documents from Blue Shield’s website.

You should provide Blue Shield with contact information, including the email address of the person who will be responsible for distributing the documents electronically.

Late enrollment

Managing late enrollment

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

- 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 to be added for an earlier effective date. The same rules pertain to dependents of late enrollees who request enrollment after the initial enrollment period.

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 in the above instances, an Employee Application must be submitted to Blue Shield no later than 31 days from the event. Pre-existing condition limitation provisions may apply, except for newborns and adopted children.

If an enrolled employee acquires a new dependent through birth, adoption, marriage or establishment of a domestic partnership, the enrolled employee may change plans at that time, if the employer offers more than one plan, and may enroll all other eligible dependents that are not enrolled.

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;
- Lost Medi-Cal or Healthy Families Program coverage as an exception to late enrollment;
- Certified on the “Refusal of Personal Coverage” section of the Employee Application during initial enrollment that coverage under another group-sponsored health plan was the reason for declining enrollment (Individual and Family Plans do not qualify as another group-sponsored health plan);
- Lost or will lose coverage under his or her other group-sponsored health plan if any of the following six situations occur:
  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 31 days of losing the other group-sponsored coverage, Medi-Cal or Healthy Families Program eligibility.

Employers should submit requests to add individuals to Blue Shield within 31 days of the event.

Blue Shield will consider retroactive additions to this time frame on a case-by-case basis. Blue Shield will not consider or permit retroactive additions that exceed 90 days.

Please note: 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 his or her coverage under Medi-Cal or the Healthy Families Program.

Initial enrollment for new employees

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

- New employees are eligible for coverage after completing your group’s waiting period (if any). The same applies to new employees’ dependents.
  - Blue Shield does not waive the waiting period for new employees unless your group’s contract specifies that the waiting period will be waived for certain employee positions. You can make changes to these position specifications during renewal.
- Blue Shield must receive a completed Employee Application no later than 31 days after a new employee completes your group’s waiting period.
- Employees and dependents who decline coverage during their initial 31-day enrollment period must complete the “Refusal of Personal Coverage” section of the Employee Application. Please retain a copy of the completed “Refusal of Personal Coverage” section and forward the original forms to Blue Shield immediately.

Renewal

This is a period when the employer can:

- Restructure the plan options they currently offer to employees
- Change waiting periods
- Change contribution levels
- Change domestic partner coverage

Note: Blue Shield offers the following two domestic partner coverage options:

1. Narrow coverage: California state registered. (Both partners have filed a Declaration of Domestic Partnership with the state of California. Both partners must be the same gender. Opposite-gender partners allowed if one partner is at least age 62 and eligible for Social Security.)

2. Broad coverage: California state registration not required. (Both partners may be the same or opposite gender.)

Credit for prior coverage

Blue Shield will provide members who terminate their 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).

You can help us speed up the enrollment process by sending us applications immediately after new employees complete them during the eligibility waiting period established for your plan. Just indicate the employee’s future effective date on the Employee Application.
Employee status changes

Name and address changes
Name and address changes can be easily made on Employer Connection. Simply log in at blueshieldca.com/employer and select the member name from your member roster. Then select Update Personal Information or Update Address once you reach the member information screen.

You can also make member address changes by submitting a request to largegroup.membereligibility@blueshieldca.com or by calling your Core Priority representative at (855) 747-5809.

Alternatively, you may make member address changes by manually requesting that your employee complete a Subscriber Change Request form and submit it to you. You will then need to fax or mail the Subscriber Change Request form to Blue Shield.

Make changes online by logging in to Employer Connection at blueshieldca.com/employer.

If an employee on leave is terminated, the individual 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 a member 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 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 continuation coverage.

For more information, see the “Coverage cancellation and options for employees” section on page 35.

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 or same-gender spouse termination or divorce occurs.

The employee’s domestic partner and children are not eligible for federal COBRA. However, eligibility requirements for continued coverage under Cal-COBRA are different from federal COBRA, so they might be eligible for Cal-COBRA continuation coverage.

The employee must provide Blue Shield with the domestic partner’s or the same-gender spouse’s forwarding address so that the individual can receive the appropriate Cal-COBRA notification by mail.

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. Blue Shield 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 length of a leave of absence is determined by your company’s personnel policy. Therefore, your company’s policy determines if or when the employee on leave is terminated. You must notify Blue Shield when you terminate the employee by submitting the information by email to largegroup.membereligibility@blueshieldca.com.
Claims process

Preferred providers
(for PPO medical plans only)
A member should never have to complete a claim form if he or she seeks service from a preferred provider because this type of provider bills Blue Shield directly. In the rare instance when a preferred provider requests full payment, the member should ask the provider to call the number listed on their Blue Shield ID card. Blue Shield will determine whether or not the member is responsible for any part of the bill (the deductible or copayment). For any amount beyond that, a preferred provider is expected to bill Blue Shield directly.

Non-preferred providers
(for PPO medical plans only)
If a non-preferred provider asks the member for payment immediately after the visit, the member should:
• Pay the bill; then
• Mail the itemized bill and a Subscriber’s Statement of Claim form to Blue Shield.

Members 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 members’ deductibles. Blue Shield will reimburse the member for the plan-covered benefit payment less the deductible and copayment amount.

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

The EOB is not a bill. However, it will reference any copayments the member owes for services (see page 61 for a sample EOB).

Grievance process

Blue Shield of California and Blue Shield of California Life & Health Insurance Company (Blue Shield Life) have established a grievance procedure for receiving, resolving and tracking members’ grievances with Blue Shield. Members, members’ providers or representatives on behalf of members can contact Member Services by telephone, online at blueshieldca.com or by mail to request a review of an initial determination concerning a claim or service.

Employees can reference their Evidence of Coverage or Certificate of Insurance for a detailed process overview about how to file a grievance, or log in to blueshieldca.com and click on Grievance Form.

Members who receive medical services outside Blue Shield’s service area should refer to the Blue Shield Global Core program section of their plan’s Evidence of Coverage or Certificate of Insurance when submitting claims.
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 the Consolidated Omnibus Budget Reconciliation Act (COBRA) or Cal-COBRA. Please advise your employees who are thinking of continuing group coverage under COBRA or Cal-COBRA to consider these options carefully before investigating individual health insurance. Companies that sell individual coverage require a review of an applicant's medical history that could result in a higher premium or a complete rejection.* And, an individual is not eligible for an individual conversion plan (ICP) or a guaranteed-issue individual plan as required by federal law (HIPAA) unless all group coverage options are exhausted including COBRA and Cal-COBRA.

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

- Report coverage cancellations to members who are no longer eligible
- Notify us prior to each individual's last day of eligibility, whenever possible, by submitting the request to largegroup.membereligibility@blueshieldca.com

Cancelling employee and dependent coverage

Employee coverage cancellation

Employees are no longer eligible for Blue Shield group coverage when their employment is terminated or their employment hours are reduced to fewer than 30 hours per week, unless employees are covered under the provisions of state law.

You can cancel an employee's coverage electronically on Employer Connection. Simply log in to blueshieldca.com/employer and select the name of the individual to terminate from the member roster. On the member information page, select Terminate Subscriber on the right-hand side and follow the instructions on the screen.

Or, you may cancel an employee's coverage by following these steps:

- Fill out an Eligibility Change Transmittal form.
- List the employee’s name, Blue Shield ID number or Social Security number and employment termination date.
- Mail, fax or email the Eligibility Change Transmittal to Blue Shield.

Cancellation requests must be submitted within 30 days of the termination date. Blue Shield will only give up to one month of credit unless subject to the provisions in Part III Eligibility of your group contract.

Helpful hints

- If you are cancelling an employee's coverage, do not list any dependent cancellations on the Eligibility Change Transmittal or Self-Reporting Group Subscriber Report. When an employee’s coverage is cancelled, all covered dependents lose eligibility and their group coverage is cancelled automatically. (You are a self-reporting group if you do not receive a billing statement.)
- If an employee voluntarily cancels his or her group coverage (when not terminating employment with your company), but later wishes to re-enroll, the employee must comply with the late-enrollee guidelines, which are outlined on page 31.
- Out-of-state employees covered under COBRA are not eligible for HMO or POS COBRA coverage if they are in an HMO or POS plan. However, they are eligible to transfer to a PPO plan if you offer one. Please contact your Blue Shield sales representative about continuation coverage for your out-of-state employees.

Please note: Blue Shield will consider retroactive cancellations that exceed 30 days on a case-by-case basis for groups with 51+ employees. Please refer to Part III Eligibility in your group contract.

* Blue Shield does not collect or use genetic information for making eligibility or rating decisions.
Dependent coverage cancellation

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

Dependent children's coverage must also be cancelled (even when the employee's coverage is not cancelled) when they:

- Reach the maximum age limit for coverage, which is effective the first day of the month following the birthday (unless disabled)
- Permanently move outside of the plan's service area if enrolled in an HMO or POS plan

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.
- A domestic partner and his or her children. 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 38.
- A same-gender spouse and his or her children. 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 38.

Please note: Federal COBRA does not require continued coverage for the domestic partner or children when the partnership is terminated.

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, follow these steps:

1. Have the employee complete a Subscriber Change Request form and list the name(s) of the dependent(s) to be disenrolled and the date(s) of cancellation. The employee should complete this form during the month the dependent becomes ineligible for coverage.
2. Verify that the form is properly completed, signed and dated, and give the employee a copy of the form.
3. List the employee's name and Subscriber ID number on the Eligibility Change Transmittal.
4. If your group is self-reporting and doesn't receive a billing statement, enter the employee name on the Self-Reporting Group Subscriber Report and the dependent dues/premiums in the “Current Dues Deletions” column. Under “Remarks” note that a dependent is being disenrolled and indicate the effective date.
5. Mail, fax or email the Subscriber Change Request and Eligibility Change Transmittal/Self-Reporting Group Subscriber Report to Blue Shield.

Please note: Cancellation requests must be submitted within 30 days of the termination date.
Federal COBRA and state Cal-COBRA continuation coverage

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

General guidelines

COBRA
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 less than 20, you must wait until the first of the next calendar year and use the above guidelines before changing your administration of continuation of group coverage from Cal-COBRA to COBRA or from COBRA to Cal-COBRA.

Cal-COBRA
Applies to employers that employed two to 19 employees for at least 50% of the working days in the previous calendar year. Cal-COBRA is also available to the employees of employers subject to COBRA after the employees exhaust all available COBRA coverage, without reaching the COBRA coverage maximum of 36 months. The Cal-COBRA continuation of coverage after COBRA is only available to employees in health plans underwritten by Blue Shield.

COBRA disability extension
A member may extend his or her 18-month COBRA coverage period to 29 months if, under the Social Security Act:

1. The member is determined to be disabled on or before the date of termination or has a reduction in hours of employment; or
2. The member is determined to be 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 COBRA coverage period. The member is responsible for notifying the employer or Blue Shield within 30 days of any final determination affecting the member’s – or the member’s dependents’ – disability status.

Non-disabled eligible family members are also entitled to this 29-month extension. Dues for months 19 through 29 are calculated at 150% of the employer’s group dues rate.

Cal-COBRA coverage for COBRA enrollees
Enrollees who reach the 18-month or 29-month maximum 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. 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.
- COBRA enrollees must exhaust all the COBRA coverage that they are entitled to before they can become eligible to continue coverage under Cal-COBRA, with the exception of domestic partners when the partnership terminates and same-gender marriages when divorce occurs.
  - When the domestic partnership terminates, same-gender spouses are divorced or the employee dies, the domestic partner or same-gender spouse may apply for continuation of group coverage under Cal-COBRA.
Cal-COBRA coverage is immediately available because a domestic partner and a same-gender spouse do not have COBRA eligibility unless the employee elects and remains enrolled in COBRA and includes the domestic partner or the same-gender spouse as a dependent.

How to enroll in Cal-COBRA

The employer, the former employee or eligible dependent should notify Blue Shield’s Cal-COBRA Administration (see below) at least 30 days prior to COBRA termination.

Blue Shield of California
Cal-COBRA Administration
P.O. Box 629009
El Dorado Hills, CA 95762-9009
Fax: (916) 350-7480

A dedicated customer service team is available to answer your questions about Cal-COBRA. Please call them at (800) 228-9476.

After receiving notification from you, the former employee or eligible dependent, Blue Shield will mail information to the former employee or eligible dependent about Cal-COBRA benefits, rates and enrollment.

The dedicated Cal-COBRA team will perform these administrative and membership duties:
- Receive qualifying event notices from you or your enrollees.
- Process qualifying event notices and apply eligibility determinations.
- Provide Cal-COBRA packets to eligible applicants (your employees and/or their dependents) within 14 days of receiving a qualifying event notice.
- Collect monthly payments for the Cal-COBRA coverage duration.
- Answer customers’ billing and eligibility questions.
- Process cancellations.

In no event will continuation of group coverage under COBRA, Cal-COBRA, or a combination of COBRA and Cal-COBRA be extended for more than 36 months from the date the qualifying event has occurred.

Individual conversion plan (ICP)

Former employees and their dependents may also qualify for an individual conversion plan.

The ICP is only available if the employee has had group coverage for three or more consecutive months. Employers are responsible for notifying their employees of the availability, terms and conditions of the ICP within 15 days of termination.

Notification requirements for COBRA plan administrators

The COBRA enrollee should contact Blue Shield for more information about continuing coverage. If the enrollee elects to apply for continuation of coverage under Cal-COBRA, the enrollee must notify Blue Shield at least 30 days before COBRA termination.

You or your COBRA administrator are responsible for notifying COBRA enrollees of their right to possibly continue coverage under Cal-COBRA at least 90 calendar days before their COBRA coverage will end.
Extension of benefits for disabled members

An extension of benefits is available when a member becomes totally disabled while covered under the plan and remains totally disabled when the group contract is terminated.

Blue Shield will extend the benefits, subject to all limitations and restrictions, for covered services and supplies directly related to the totally disabling condition, illness or injury until the first of the following occurs:

• 12 a.m. on the day following a 12-month period from the date the group contract terminated
• The date when the covered person is no longer totally disabled
• The date when the covered person’s maximum benefits are reached
• The date when a replacement carrier provides coverage that is not subject to a pre-existing condition exclusion or limitation as to the totally disabling condition

Members may contact Direct Sales at (800) 910-1010 with questions.

A licensed physician must provide Blue Shield with 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 mail both forms to Blue Shield; and
• The primary care physician must submit an Attending Physician Statement of Disability form to Blue Shield.
Coverage options for employees and retirees who have Medicare coverage

In addition to COBRA, employees and dependents who have Medicare coverage also have other health coverage options, which are described below.

Active employees

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

For active employees:
• 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.

Employer groups' disclosure to Centers for Medicare & Medicaid Services (CMS) requirement

Employer groups must disclose directly to CMS on an annual basis whether or not the prescription drug coverage provided to their Medicare-eligible individuals is creditable. The disclosure must be completed no later than 60 days following the beginning of the employer group’s plan year (renewal year).

Employer groups that provide prescription drug benefits to Medicare Part D eligible individuals must submit the online disclosure form directly to CMS.

The disclosure form that must be completed and submitted to CMS can be found at the CMS website at: www.cms.hhs.gov/CreditableCoverage/45_CCDisclosureForm.asp, and instructions are available at: www.cms.hhs.gov/CreditableCoverage/40_CCDisclosure.asp#TopOfPage.

If the employer group does not provide prescription drug benefits to any Medicare Part D eligible individual, no disclosure form needs to be completed for the plan year.

For additional coverage options for employees and dependents, please go to blueshieldca.com, select Employers, then click on Blue Shield Plans. You can also contact your Blue Shield sales representative to learn more about:
• Blue Shield Individual and Family Plans (IFP)
• Blue Shield Individual Conversion Plans
• Medicare Supplement Plan or Blue Shield 65 Plus℠ (HMO) for retirees with Medicare coverage

Medicare claims appeal process

Members enrolled in Blue Shield 65 Plus℠ Choice Plan (HMO) may contact the Member Services department seven days a week from 8 a.m. to 8 p.m. at (800) 776-4466 (TTY: (800) 794-1099) to appeal already adjudicated claims.

Completed appeal forms must be mailed to Blue Shield of California at:

Blue Shield 65 Plus HMO
Medicare Grievances and Appeals Resolution Department
P.O. Box 927
6300 Canoga Ave.
Woodland Hills, CA 91365-9856

Member Services:
• Voice Response Unit is available 24/7.
• From October 1 through February 14, Member Services is open from 8 a.m. to 8 p.m. seven days a week. After February 14, calls will be handled by the automated system on weekends and holidays.
Group billing procedures

For a quick summary of group billing procedures, see Table 4 below, which is a handy checklist of the items that you must submit to Blue Shield each month.

If you have any questions about changes to your group’s coverage, please contact Core Priority at (855) 747-5809.

Coverage from Blue Shield is offered on a prepaid basis. Blue Shield 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.

If you have questions about billing discrepancies, please call your Blue Shield group billing representative at the number listed on your statement.

Table 4

| Enclosed Items*                    |                                                                 |
|-----------------------------------|--|-------------------------------------------------------------------|
| ✔️ A check for your group’s monthly dues payment |   |                                                                   |
| ✔️ The remit slip from the bottom of the billing statement’s first page |   |                                                                   |
| ✔️ An Eligibility Change Transmittal if additional employee coverage changes, deletions or transfers have occurred and you haven’t already submitted them to Blue Shield |   |                                                                   |

* Please keep a copy of all items for your files.

Standard positive billed groups

Your monthly billing statement includes both a summary of the amount billed and current billing detail. There is a section on your billing statement with a summary by product and membership.

You should:

• Submit cancellation requests within 30 days of the termination date. Retroactive cancellations that exceed 30 days will not be approved.
• Verify monthly that your changes are accurately reflected on the Group Payment Request.
• Send the billing statement remit slip with your monthly premium, along with a list of any terminations for the month.

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

If you submitted additions, deletions 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 billing statement and Blue Shield will credit or debit your account for the correct amount on your next statement.

Paying dues for new additions

You do not need to pay dues for new employees or dependents until Blue Shield bills you for any additional dues on your next billing statement. Please note that the benefit administrator is responsible for verifying that the request is being processed by reviewing your billing statement each month. If the requested changes are not reflected on your invoice within two months, please contact your Billing Team at the phone number on your billing statement.
Stopping payment for deletions
If an employee is terminated during the month:
• Please submit an Eligibility Change Transmittal immediately after the employee's termination date.
• The employee's coverage will remain in effect until the end of the billing period and dues are payable for that period.
• The terminated employee will be deleted from the next billing statement.
• 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 billing statement and Blue Shield will credit you for the deleted dues on your next billing statement. If any submitted changes do not appear within two billing cycles, contact your group billing representative at the number listed on the billing statement.

Identifying class and plan transfers
When your company has more than one class or health plan, identify class and health plan transfers on the Subscriber Change Request. These changes will appear on your next bill. For example, when an employee transfers from a Blue Shield PPO plan to Blue Shield Access+ HMO during open enrollment, you must submit a Subscriber Change Request.
Self-reporting billing procedures

Self-reporting billing is a contractual agreement made at initial enrollment of the account or upon renewal. If your company is a self-reporting group, you will not receive a billing statement.

Table 5 below is a handy checklist of the items that you need to submit to Blue Shield each month.

<table>
<thead>
<tr>
<th>Enclosed Items*</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ A check for your group’s monthly dues payment</td>
</tr>
<tr>
<td>✓ An Eligibility Change Transmittal if additional employee coverage changes, deletions or transfers are required</td>
</tr>
<tr>
<td>✓ A Self-Reporting Group Subscriber Report</td>
</tr>
</tbody>
</table>

Self-reporting billing is an option available to groups that meet the minimum requirements of 300 enrolled subscribers and have the ability to submit payment files electronically.

Important points about the Self-Reporting Group Subscriber Report

- Forward this report to Blue Shield prior to your group’s payment due date, and include your dues payment.
- The report should list all existing employees, along with any new additions, changes (including non-money changes) and cancellations. Required data includes the group number, employee name, employee Social Security number, amount being paid and effective date of any changes.
- New employees will not be added to the group, and payments for submitted claims cannot be issued until the Employee Applications are received and processed by Blue Shield.
- You will not receive a monthly billing statement, but you may periodically request an eligibility report of enrolled employees.
- Cancellations and other changes must be reported on a timely basis (within 30 days from the date the request is received) so that retroactive dues adjustments are not necessary and claims are not paid for ineligible employees and dependents.

Eligibility file procedures

Eligibility files must be submitted electronically in the ANSI 834 file format. The file can be submitted on a weekly, bimonthly or monthly basis. The frequency of submission will be determined during the initial group setup. Manual updates will not be accepted.

Audit file procedures

Because you do not receive a billing statement, Blue Shield will conduct a quarterly full-file audit to ensure the accuracy of your group’s eligibility. This procedure includes these steps:

- You or your third-party administrator (TPA) must submit the quarterly full eligibility file electronically to Blue Shield in the ANSI 834 file format.
- Blue Shield will process the quarterly eligibility audit file, comparing the group’s ANSI 834 file with Blue Shield of California’s membership system, and return eligibility discrepancies to the group or TPA within two business days.
- The group or TPA has 10 business days to respond to Blue Shield. If no response is received, Blue Shield will assume the eligibility is correct. Any adjustments and/or corrections requested after the date of the audit will be declined.

This audit file is for eligibility comparison only. Any eligibility changes must come through the group’s ANSI 834 file. Eligibility will not be updated with this audit file. To avoid discrepancies, please make sure your eligibility files are current.

* Please keep a copy of all items for your files.
Payment procedures

Here is a guide to payment procedures for self-reporting groups:

• The preferred method of submitting monthly dues remittance information is an electronic ANSI 820 file format listing each individual and the billing period being paid.

• Another option is to submit an Excel file by email. Do not send printed reports – they cannot be processed.

• The ANSI 820 or Excel file must be received no later than the first of the month that coverage is provided.

• Blue Shield will provide a discrepancy report within 10 business days to the group or TPA.

• The group or TPA has five business days to respond to Blue Shield.

• Cancellations and/or deletions must be reported on a timely basis so that retroactive dues adjustments do not exceed 60 days from the date the request is received.

• Any cancellations and/or deletions requested retroactively beyond 60 days will not be honored.

Blue Shield coverage is offered on a prepaid basis. Payment must be received on or before the due date to keep your coverage current. Failure to pay on or before the due date will result in termination of your group coverage.
Group delinquency

The delinquent notification policy and procedures are listed below:

- Blue Shield’s policy is to bill groups prior to the coverage due date.
- Group dues are delinquent on the day following the due date printed on your billing statement.
- Blue Shield will notify a delinquent account 15 days prior to cancelling the account for nonpayment.
- If payment is not received, Blue Shield will cancel your group health plan’s coverage.
- If the dues payment is received in full before cancellation, Blue Shield will remove the delinquent status from your account.

Late-payment notice for delinquent groups

A Prospective Notice of Cancellation will be issued when dues have not been received 15 days after the due date. This notice contains:

- The total amount due, which includes 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 your dues

If you have submitted payment on time and feel you have received the Prospective Notice of Cancellation in error, please contact your group billing representative at the telephone number printed on your billing statement.

Group cancellation procedures

Requesting cancellation of your group account

Blue Shield requires 30 days’ advance notice of cancellation in writing. Notification can be submitted by one of two options:

1. Sending a letter on business letterhead; or
2. Making a notation on your billing statement.

Your account will be reconciled to the effective date of cancellation, and written notification of your account’s status will be sent to your billing address on record.

Nonpayment of dues

Blue Shield considers an account delinquent when group dues are not received by the due date printed on the Group Payment Request. Here is the procedure for delinquent accounts:

- Blue Shield will send you a 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 payment of all outstanding dues is not received within 15 days after mailing the Prospective Notice of Cancellation, the account will be cancelled 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 Request unless requested otherwise.
- Blue Shield 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.
- The contract will not be reinstated. Blue Shield requires that the employer complete a new application for coverage.
- A new contract will be issued only upon demonstration that the employer meets all underwriting requirements.
- The employer will remain financially responsible for all outstanding dues incurred while the account was in effect.

Please note: If your group account coverage is cancelled for any reason, you are responsible for immediately notifying your employees and COBRA beneficiaries about the coverage termination.
How to manage your group dental benefits

The following is designed to make it easier for you to enroll and manage your group dental plan if you’ve selected Blue Shield dental coverage for your employees.

By purchasing 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
- Single bill for medical and dental PPO plans

Employee status change

You are responsible for maintaining accurate eligible employee information.

- A Subscriber Change Request form (C675-1) must be completed when there is a change in status to an employee, or their dependents, spouse or domestic partner.
- In cases of births, adoptions, marriages and divorces, the employee must submit the Subscriber Change Request form no later than 31 days after the change.
- If the employee does not submit the form within 31 days after the change, they will need to wait until your group’s next open enrollment period.
- If the employee decides to add coverage for an existing dependent or spouse, the employee must wait until your group’s next open enrollment period.
- Employees with family coverage should notify Blue Shield when a dependent child reaches age 26.

Enrolling employees and dependents

As new employees, their spouse/domestic partner and their dependents become eligible for benefits, or once the employee has fulfilled your company’s benefits waiting period, they should complete a new Employee Application (C12914) with the following information:

- On the upper right-hand corner of the application, fill in the group number, plan number and the effective date for coverage (OED).
- The effective date for an added employee or dependent must be the first day of the month following your group’s benefit waiting period.
- New enrollment applications should be faxed or mailed to Blue Shield prior to the 25th of each month to be included in the network provider eligibility roster for the following month.

Invoice procedures

Membership changes should be faxed or mailed to Blue Shield prior to the 15th of each month 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 employees’ dues from the amount due as it will result in a negative balance on the next month’s bill. The termination information should be submitted on the Employee Change Transmittal form (C3843). The amount will then be credited on the next billing and the account will remain current.

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 the employee understand their benefits and options. For assistance in planning your group’s open enrollment period, please contact your broker or Blue Shield sales representative.
Dental HMO provider change

Dental HMO members may change their current dental provider at any time by calling Dental Member Services at (888) 702-4171.

Changes are effective the first day of the following month a request is received.

Submitting a claim

Dental HMO 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 claims handling

• Providers in the dental PPO network will submit claims for payment after services have been received by the members.
• The member is 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.

Nationwide dental provider network

In addition to the large California provider network, the national network* 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 or HMO network by:

• Going to blueshieldca.com to find a provider
• Calling Dental Member Services at (888) 702-4171 to request a list of PPO or HMO dental providers

Forms

Forms for administering group dental benefits are listed on page 56. You can print them from blueshieldca.com or order them by contacting your Blue Shield sales representative.

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 sales representative.

<table>
<thead>
<tr>
<th>Dental Member Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>(888) 702-4171</td>
</tr>
<tr>
<td>Monday through Friday, 5 a.m. to 8 p.m. Pacific time</td>
</tr>
</tbody>
</table>
Grievance process

Members may contact Dental Member Services by phone or letter to request a review of an initial determination concerning a claim or service. Members may contact Dental Member Services at the phone number listed above. If a phone inquiry to Dental Member Services does not resolve the question or issue to a member’s satisfaction, the member may submit a formal grievance at that time. Dental Member Services can initiate a grievance on the member’s behalf. The member may also initiate a grievance by submitting a letter or a completed grievance form. The member may request this form from Dental Member Services. If the member wishes, 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., 12th 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 members’ dissatisfaction.

Please note: If an employer’s health plan is governed by the Employee Retirement Income Security Act (ERISA), employees might 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.

Dental Member Services – Eligibility, billing and account management
Phone: (800) 325-5166
Fax: (877) 251-0889
Blue Shield of California
Installation & Membership – Group
P.O. Box 629014
El Dorado Hills, CA 95762-9014
Attention: Dental Eligibility Changes
Email: LargeGroup.MemberEligibility@blueshieldca.com
Monday through Friday, 8 a.m. to 5 p.m. Pacific time

Dental Claims and Benefit Inquiry
(888) 702-4171
Monday through Friday, 8 a.m. to 5 p.m. Pacific time
How to manage your group vision benefits

The following is designed 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.

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

- Single enrollment form for both vision and medical
- Single point-of-contact for adding and removing employees and their dependents
- Single bill for both medical and vision plans
- Flexibility to continue offering Blue Shield vision coverage if medical coverage is cancelled or vice versa

Enrolling employees and dependents

As new employees, their spouse/domestic partner 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 (C15390) or the Vision Only Enrollment form (ABU1189).

Note: The effective date for an added employee or dependent must be the first day of the month following your group’s benefit waiting period.

Employee status change

You are responsible for maintaining accurate eligible employee information.

- Each month you will receive a premium billing statement that includes all eligible members for the next month. Review your premium billing statement to confirm accurate eligible employee information.
- A Subscriber Change Request form (C675-1) must be completed 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 and note any enrollment changes. You can submit this form each month noting the enrollment changes.

Invoice procedures

Membership changes should be faxed or mailed to Blue Shield prior to the 15th of each month 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 employees’ dues from the amount due as it will result in a negative balance on the next month’s bill. The termination information should be submitted on the Employee Change Transmittal form (C3843). The amount will then be credited on the next billing, and the account will remain current.

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 sales representative.

Nationwide vision provider network

In addition to having one of California’s largest provider networks, Blue Shield helps 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.
- 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 printed from our website. Go to blueshieldca.com/employer and click on Vision Plans. Or, you can call customer service for assistance at (877) 601-9083.
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 (C-4669-61). 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

Forms

Forms for administering group vision benefits are listed in the appendix. You can print them from blueshieldca.com or order them by contacting your Blue Shield sales representative.

Vision Member Services

Vision Member Services can assist you with questions about eligibility, billing or claims. For questions about your plan or renewal rates, please contact your Blue Shield sales representative.

Grievance process

Members may contact Vision Claims and Benefit Inquiry by phone or letter to request a review of an initial determination concerning a claim or service. Members may contact Vision Claims and Benefit Inquiry at the phone number listed above. If the phone call to Vision Claims and Benefit Inquiry does not resolve the question or issue to a member’s satisfaction, the member may submit a formal grievance at that time. Vision Claims and Benefit Inquiry can initiate a grievance on the member’s behalf. The member may also initiate a grievance by submitting a letter or a completed grievance form. The member may request this form from Vision Claims and Benefit Inquiry. If the member wishes, Vision Claims and Benefit Inquiry can assist in completing the grievance form. Completed grievance forms must be mailed to the Vision Plan Administrator at:

Blue Shield of California
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 members’ dissatisfaction.

Please note: If an employer’s health plan is governed by the Employee Retirement Income Security Act (ERISA), employees might 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

The following is designed to make it easier for you to enroll and manage your group term life insurance plan.* By purchasing life and 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
• Single point-of-contact for adding and deleting employees and dependents
• Combined billing statement for your medical and life insurance rates, unless you self-report your life insurance billing

Employee status change
You are responsible for maintaining accurate eligible employee information.

• 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
  – Portability of Supplemental/Voluntary Life (for groups participating in Supplemental/Voluntary Life) upon termination of employment.

Enrolling employees and dependents
All employees who are electing a Blue Shield medical plan, 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.

Employees who did not apply for coverage when they were first eligible 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 meeting 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.

Certificate of Insurance
For group policies effective January 1, 2017, or later, a group-specific Certificate of Insurance will be included with your group policy. You will be responsible for distribution to covered employees.

Questions about Blue Shield Life’s Certificate of Insurance should be directed to your health plan billing representative, or call Blue Shield Employer Services at (800) 325-5166.

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* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).
Counseling employees on naming beneficiaries

Employees may change their beneficiary at any time, as often as they wish, using a Beneficiary Change form (ABU1165). You are responsible for maintaining your employees’ 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 a 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.

How to submit a life or accidental death claim

For life insurance or accidental death claims, the following documents are required from the group administrator:

- Proof of Death claim form (ABU1180) signed by an authorized group contact
- Original certified death certificate
- Proof of Beneficiary Designation
  - Original Group Life Insurance Plan Employee Enrollment form
  - Any change of beneficiary forms since enrollment, if applicable
- Two months’ pay stubs showing number of hours the employee has worked
- In cases of accidental death
  - The official investigative report (i.e., police, accident, fire, FAA, OSHA)
  - Autopsy report
  - Toxicology report, and/or
  - Any medical records requested by Blue Shield

If all the primary beneficiaries die before the insured, then the benefit will be paid to the contingent beneficiary(s). If there is no contingent beneficiary(s), the life claim will be paid according to the Beneficiary and Facility of Payment provisions in the policy.

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

Mail Proof of Death claim form and documentation to:

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

How to submit a waiver of premium claim

If an employee becomes totally and continuously disabled, they may be eligible for a waiver of premium. Proof of total, 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 attending physician
- Attending Physician Statement of Disability (CP1012-LO)
- Proof of current beneficiary designation
- Two months’ pay stubs showing number of hours the employee has worked

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 or by law.

Blue Shield Life Claims Services
Phone: (888) 800-2742
Fax: (800) 329-2742
Monday through Friday, 9 a.m. to 5 p.m.
Pacific time
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.

A 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 31 days of termination of coverage. Only amounts of $2,000 or higher are eligible for conversion.

Please refer to your plan policy/certificate 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 a life or an accelerated death benefit (ADB) claim

If one of your employees becomes terminally ill, they may be eligible to withdraw an ADB benefit, subject to the following minimums and maximums:

- Maximum allowed is 50% of benefit or $250,000, whichever is lower.
- Minimum allowed is 10% of benefit or $5,000, whichever is greater.
- Minimum of $15,000 in coverage is required to receive ADB.

The following documents are required:

- An Accelerated Death Benefit claim form (ABU1139) completed by the employer, employee and/or attending physician
- Two months' pay stubs showing number of hours the employee has worked

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

Mail Accelerated Death Benefit claim form and documentation to:
Blue Shield Life
Specialty Benefits Operations
4203 Town Center Blvd.
El Dorado Hills, CA 95762

How to convert from group term life to individual whole life

All active employees covered under the group policy can convert to an individual whole life policy without evidence of insurability if they lose their job, their benefits are reduced 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 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.

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

Group term life, supplemental 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

* 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 effect, 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.
(CP1020) within 31 days of the termination or benefit reduction in order to be eligible for the conversion policy. After 31 days, the application will be declined.

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. The premium rate is based on the age of the applicant and the amount being converted. Premium information can be found in 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 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 that terminated, less the amount of the group life insurance for which the person becomes eligible.

Please refer to your plan policy/certificate 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 in the appendix. 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.

Grievance process

Members may contact Blue Shield Life by phone or letter to request a review of an initial determination concerning a claim or service. If the phone or written inquiry does not resolve the question or issue to the member’s satisfaction, the member may submit a formal grievance at that time. The Blue Shield Life representative can initiate a grievance on the member’s behalf. The member may also initiate a grievance by submitting a letter or a completed grievance form. The member may request this form from Blue Shield Life. If the member wishes, Blue Shield Life can assist in completing the grievance form. Completed grievance forms must be mailed to the address below:

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

The Blue Shield Life 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 might 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.

Blue Shield Life Member Services
Phone: (888) 800-2742
Fax: (800) 329-2742
Monday through Friday, 9 a.m. to 5 p.m.
Pacific time
To get copies of forms listed below or any additional forms, go to blueshieldca.com and click on Employers. There you’ll find all employer and employee forms available to print at your convenience. If you need assistance, contact your Blue Shield sales representative.

## Employer forms

### Changes and terminations

<table>
<thead>
<tr>
<th>Form Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Change Transmittal (C3843)</td>
<td>Use this form to submit a monthly summary of employee changes.</td>
</tr>
<tr>
<td>Employee Cancellation Transmittal Request (A36965)</td>
<td>Use this form to submit a monthly summary of employee terminations.</td>
</tr>
</tbody>
</table>

### Employee forms

<table>
<thead>
<tr>
<th>Form Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midsize and Large Group (51+) Employee Application (C15390)</td>
<td>Employees should complete this form to enroll in a group medical plan, group vision plan or group term life insurance policy.</td>
</tr>
</tbody>
</table>

## Employee forms

### Additions, deletions and other changes

### Health plans

<table>
<thead>
<tr>
<th>Form Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending Physician Statement of Disability (C4425)</td>
<td>To file for an extension of disability benefits, the employee’s primary care physician must complete and submit this form to Blue Shield. In addition, employees must complete a Subscriber Statement of Disability form and the employer must fill out a Notice of Total and Permanent Disability form.</td>
</tr>
<tr>
<td>Conversion to Individual Coverage Request Form (A16170)</td>
<td>Employees who have held group coverage for three or more consecutive months are eligible to transfer to an individual conversion plan when they retire, leave the job or become ineligible for group coverage.</td>
</tr>
<tr>
<td>Declaration of Disability for Over-Age Dependent Children (C3674)</td>
<td>Enrolled dependent children who would normally lose their eligibility under this plan solely because of age, and who are physically or developmentally disabled, may have their eligibility extended by completing this form.</td>
</tr>
<tr>
<td>Refusal or Cancellation of Personal Coverage (C13124)</td>
<td>Complete if the employee, spouse, domestic partner or dependent(s) are refusing employer’s health or dental plan coverages.</td>
</tr>
<tr>
<td>Request for Continuity of Care Service (C13095-540-CR)</td>
<td>New enrollees with qualifying conditions may be able to complete care with a non-network provider.</td>
</tr>
<tr>
<td>Subscriber Change Request (C675-1-ML)</td>
<td>Employees must complete this form any time they make changes to their personal information or any type of coverage changes, such as adding or deleting dependents.</td>
</tr>
<tr>
<td>Subscriber Statement of Disability (C12198)</td>
<td>To file for an extension of disability benefits, employees must complete this form. In addition, benefit administrators need to complete a Notice of Total and Permanent Disability form.</td>
</tr>
</tbody>
</table>
### Employee forms

#### Additions, deletions and other changes (continued)

#### Life insurance plans

- **Authorization for Blue Shield of California Life & Health Insurance Company to Disclose Personal & Health Information to a Third Party (C15625)**
  Employer and employee should complete this form when changing from group life insurance to individual life insurance.

- **Conversion to Individual Policy from Group Life Insurance (CP1020)**
  Employer and employee should complete this form when changing from group life insurance to individual life insurance.

- **Life and AD&D Beneficiary Change Request (ABU1165)**
  Employees should complete this form when they have additions, deletions and other changes to their coverage.

#### COBRA elections

- **Group Continuation Coverage (COBRA) Election (C11825-RTM) federal form**
  If you are self-administering or have a third-party federal COBRA administrator and you have qualified beneficiaries electing to participate in COBRA, they must complete this form.

- **Cal-COBRA form (C18157)**
  For employees who have exhausted coverage under federal COBRA and were not entitled to the maximum period or have been covered as a domestic partner and the partnership terminated.

#### Claims

#### Health plans

- **Subscriber’s Statement of Claim (CLM-14850)**
  Employees should use this form ONLY when the Provider of Service does not submit their claim directly to Blue Shield. This is for Blue Shield of California plans.

- **Blue Shield of California Prescription Drug Benefit – Direct Reimbursement Claim (0191-20)**
  Employees who are members of PPO plans that have the Blue Shield Rx Program should complete this direct reimbursement form when they have used a non-network pharmacy, or when they did not present their ID card at a network pharmacy during the first 30 days of eligibility.

- **International Claim Form (C14764)**
  Employees should only use this form if they paid out-of-pocket for covered services while out of the country.

- **Blue Shield Global Core International Claim Form**
  Use this form if the out-of-country provider directly billed Blue Shield of California for covered services.

#### Dental plans

- **Dental Claims form (C11716)**
  Employees should complete this form to submit a dental claim for services received from a non-network provider.

#### Vision plans

- **Vision Claims form (C-4669-61)**
  Employees should complete this direct reimbursement form for services received from a non-network provider.
### Employee forms

#### Claims (continued)

#### Life insurance plans

- **Accelerated Death Benefit Claim (ABU1139)**
  Employer, employee and attending physician will need to complete this form for insured persons to continue to receive life insurance coverage without payment of premiums if they become terminally ill.

- **Life and AD&D Waiver of Premium Claim (ABU1182)**
  Employer, employee and attending physician will need to complete this form for insured employees who become totally disabled as defined in the Certificate of Insurance.

- **Life Insurance Proof of Death Claim (ABU1180)**
  Employers should complete this form for the beneficiary or dependent.

#### Other

- **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.
Group summary bill

Group and subgroup numbers
You will find group and subgroup numbers embedded within the account number located under the mailing address on your first month's bill. Your account number is "1" followed by your group number beginning with the letter "W" and followed by seven numbers, then followed by your subgroup number, which is four numbers.

Example:
Account number: 1W00010261000
Group number: W0001026
Subgroup number: 1000

Sample group summary bill

New integrated bill format

A Bill date
B Billing period and due date
C Previous amount due – The total amount due from the prior month's billing statement
D Payment – Payment received since last billing statement
New integrated bill format

- **Billing detail** – Current charges
- **Total current adjustment** – Identifies the net change of subscriber and member since last billing statement
- **Product summary** – Provides a summary of the number of subscribers and dues by products
- **Contract counts** – Identifies a summary of contract counts

### Product Summary

**Contract**

<table>
<thead>
<tr>
<th>Contract Type</th>
<th>Subscriber Count</th>
<th>Current Charges</th>
<th>Adjustments</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>17</td>
<td>12,784.34</td>
<td>0.00</td>
<td>$12,784.34</td>
</tr>
<tr>
<td>2 Party</td>
<td>3</td>
<td>4,737.66</td>
<td>0.00</td>
<td>$4,737.66</td>
</tr>
<tr>
<td>Family</td>
<td>4</td>
<td>9,023.32</td>
<td>0.00</td>
<td>$9,023.32</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>$26,545.32</td>
<td></td>
<td>$26,545.32</td>
</tr>
</tbody>
</table>

**Account Number:**

**Invoice Number:**

**Blue Shield of California**

*Installation & Membership - Large Group*

P.O. Box 629014

El Dorado Hills CA 95762-9014

**blue of california**

An Independent Member of the Blue Shield Association

Page 3 of 10

**Membership Summary**

**Total Current Adjustments**

- Net Change Subscribers: 0
- Net Change Members: 0

**Contract Counts**

- Total Subscriber only: 224
- Total Subscriber and 1 dep: 15
- Total Subscriber and 2+ dep: 11

**Billing Detail**

<table>
<thead>
<tr>
<th>Subscriber Name</th>
<th>SubscriberId</th>
<th>Employee Id</th>
<th>Health</th>
<th>Dental</th>
<th>Vision</th>
<th>Life</th>
<th># Per</th>
<th>Total</th>
</tr>
</thead>
</table>

**Current Charges**
Employee Application quick guide

This guide will help you identify the fields that require completion on the Employee Application. Missing or illegible information in these fields could cause delays in enrollment.

The critical fields on the Employee Application indicate information required to complete the enrollment of each employee. Missing or illegible information in these fields will hold up processing. Fields marked important signify information that allows us to provide the highest level of customer service to your employees.

### Critical fields

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last name, first name</td>
<td>Full name of enrolling employee; middle initial is optional</td>
</tr>
<tr>
<td>Mailing address</td>
<td>Member communication, including ID card, will be mailed to this address. For HMO/POS plans, the home physical address (directly below mailing address) is required if different from the mailing address.</td>
</tr>
<tr>
<td>Full-time hire date</td>
<td>Date of full-time status, working 20 or more hours per week</td>
</tr>
<tr>
<td>Date of birth</td>
<td>Month, day and year of birth</td>
</tr>
<tr>
<td>Sex (gender)</td>
<td>Male or female</td>
</tr>
<tr>
<td>Job title</td>
<td>Required if eligibility is based on job title</td>
</tr>
<tr>
<td>Social Security number</td>
<td>Nine-digit Social Security number (required for both employees and dependents age 42 or older)</td>
</tr>
<tr>
<td>Plan/benefit information</td>
<td>Medical benefits and optional benefits chosen</td>
</tr>
<tr>
<td>Dependent information</td>
<td>Relationship, gender, first name, last name (if different from the enrolling employee), date of birth and benefit option (medical/dental). If the enrollee has an over-age (older than 26) disabled dependent, a Declaration of Disability for Over-Age Dependent Children form must be included.</td>
</tr>
<tr>
<td>Signature of employee and date</td>
<td>Employee’s signature and date on the Authorization section</td>
</tr>
</tbody>
</table>

### Important fields

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer (group) name</td>
<td>Full business name</td>
</tr>
<tr>
<td>Department code</td>
<td>This is your assigned group number and is needed only if you use a department code to structure your billing units.</td>
</tr>
<tr>
<td>Home physical address</td>
<td>The home physical address is needed only if it differs from the mailing address.</td>
</tr>
<tr>
<td>Life insurance/AD&amp;D amount</td>
<td>If graded life insurance, provide the volume of life insurance/AD&amp;D coverage.</td>
</tr>
<tr>
<td>Home phone number</td>
<td>Area code and seven-digit phone number</td>
</tr>
<tr>
<td>Job title</td>
<td>Job classification of employee</td>
</tr>
<tr>
<td>Marital status</td>
<td>Single, married or domestic partner</td>
</tr>
<tr>
<td>Provider information (HMO and dental HMO)</td>
<td>Primary care physician name, provider number, existing patient designation, name of dental center and dental center number; applies to employee and all dependents. If left blank, Blue Shield will assign a primary care physician.</td>
</tr>
<tr>
<td>Names of primary beneficiary and contingent life insurance beneficiaries</td>
<td></td>
</tr>
</tbody>
</table>

If you have questions, please contact your Blue Shield sales representative.
Explanation of Benefits

The Explanation of Benefits or EOB provides members with clear information about their claim and benefit information including:

1. **Claims Summary at a Glance box:**
   - Displays patient responsibility amount and deductible status
   - Summarizes key information

2. **Patient’s responsibility amount**

3. **Claims details**

4. **Detailed grid that clarifies amount allowed versus amount billed**

5. **Helpful definitions**

**Sample EOB**
Sales contact information

**Northern California**

El Dorado Hills
4207 Town Center Blvd.
El Dorado Hills, CA 95762
Toll-free: (855) 937-4538

Fresno
5250 N. Palm Ave., Suite 120
Fresno, CA 93704
Toll-free: (855) 937-4538

San Francisco
50 Beale St.
San Francisco, CA 94105
Toll-free: (855) 937-4538

San Jose
One Almaden Blvd., Suite 701
San Jose, CA 95113
Toll-free: (855) 937-4538

Walnut Creek
2175 N. California Blvd., Suite 250
Walnut Creek, CA 94596
Toll-free: (855) 937-4538

**Southern California**

Los Angeles
100 N. Sepulveda Blvd., 20th Floor
El Segundo, CA 90245
Toll-free: (855) 937-4538

Ontario
3401 Centre Lake Plaza Drive, Suite 400
Ontario, CA 91761
Toll-free: (855) 937-4538

Orange
555 Anton Blvd., 8th Floor
Costa Mesa, CA 92626
Toll-free: (855) 937-4538

San Diego
2275 Rio Bonito Way, Suite 250
San Diego, CA 92108
Toll-free: (855) 937-4538