Blue Shield of California Small Group Underwriting Guidelines for Producers

Effective January 1, 2026
Groups of 1 to 100 employees

This booklet contains guidelines that represent Blue Shield's general approach to underwriting new and existing small group business for health plans and specialty benefits plans. These guidelines apply to coverage written by either Blue Shield of California or Blue Shield of California Life & Health Insurance Company. We will make every effort to keep you informed and up to date on changes to these guidelines.

Only Blue Shield may make the final decision to accept or decline coverage for a case or assign an effective date for coverage. Producers are not authorized to bind or guarantee coverage or assign a specific rate or effective date for coverage. Please advise all prospective groups to maintain their current coverage until Blue Shield notifies them in writing of any acceptance into a Blue Shield plan.

Please note:
Blue Shield of California is a licensed healthcare service plan under provisions of the California Health & Safety Code Sec.1340 et seq. (the "Knox-Keene Act").
Blue Shield of California Life & Health Insurance Company is a licensed life and disability insurer under the provisions of the California Insurance Code.

Blue Shield of California is an independent member of the Blue Shield Association A16060-REV (4/30/2025)

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Section I: Health Plan General Requirements

To qualify for any Blue Shield health plan coverage, a group must meet the criteria outlined below in the small employer defined, small employer eligibility requirements, and other employer requirements sections.

In applying these criteria, Blue Shield will adhere to the guaranteed-availability and guaranteed renewability requirements of the Patient Protection and Affordable Care Act (ACA). ACA requirements do not supersede standards or requirements of California law, except to the extent that state law would prevent the application of ACA requirements.

Small employer defined (applies to medical plans only)

The group must qualify as a "small employer" as defined by California Health and Safety Code and the ACA, as follows:

The Health and Safety Code sets forth the following standards:

- The group must be a person, firm, proprietary or nonprofit corporation, partnership, public agency, association, or guaranteed association.
- The group must employ at least one "common-law employee" who is also an "eligible employee" (see page 10).
    - A common-law employee is defined by the Internal Revenue Service (IRS) as anyone who performs services for an employer if the employer can control what will be done and how it will be done.
    - For purposes of determining whether an employer has one employee, sole proprietors and their spouses or domestic partners, and partners of a partnership and their spouses or domestic partners, and 2% S-Corporation shareholders are not employees.
- The group employed one to 100 common-law employees, the majority of whom were employed within this state, on at least 50% of its working days during the preceding calendar quarter or calendar year. In determining whether to apply the preceding calendar quarter or year test, Blue Shield will use the test that ensures eligibility.
    - In determining the number of employees for small employer eligibility, groups that are affiliated companies and that are eligible to file a combined state tax return shall be considered one employer, even if they are not currently filing together. The affiliated companies are treated as a single employer and are written under the same contract.
- The group is not formed primarily for the purpose of obtaining health coverage.
- The group offers health plan coverage to 100% of its eligible employees.
- When health coverage is obtained through any arrangement, including associations, member(s) of that arrangement or group that qualify as small employers will receive small group coverage, unless the arrangement, including a Multiple Employer Welfare Arrangement (MEWA), Taft-Hartley plan or Davis Bacon Trust, can demonstrate that the group is eligible for large group coverage consistent with the California Health and Safety Code and other applicable law or regulatory guidance.

The ACA sets forth the following standards:

- "Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least one but not more than 100 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer is based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

- For plan years commencing on or after January 1, 2016, for non-grandfathered plans, a small employer is determined using the definition of "employee." An "employee" is defined as a full-time employee or full-time equivalent employee as those terms are defined in Internal Revenue Code Section 4980H(c)(2):
    - A "full-time employee" is an employee who has, on average, at least 30 hours of service per week, or at least 130 hours of service total during a calendar month.
    - The number of "full-time equivalent employees" is determined as follows:
        1. Combine the number of hours of service of all non-full-time employees for the month, but do not include more than 120 hours of service per employee.
        2. Divide the total by 120.
        3. If the result is a fraction, round down to the next whole number.
- ACA guaranteed-availability generally requires Blue Shield to accept every small employer (as defined under the ACA) in California that applies for small group coverage.

Small employer eligibility requirements

A small employer that meets the following eligibility requirements is eligible for Blue Shield's small group health plans on a guaranteed issue and guaranteed renewable basis:

- Must qualify as a "small employer" under state and ACA standards, as applicable. Small employers have guaranteed availability rights under the ACA (see above for the applicable ACA definition of "small employer".)
- Must be actively engaged in business or service.
- Must have and maintain applicable business licensure, permits, etc. allowing the company to conduct business in California.
- All employees must be covered by workers' compensation when required by law.

The following groups are not considered small employers:

- A group not qualifying as a "small employer" under state and ACA standards, as applicable.
- Groups with only a sole proprietor and/or a sole proprietor's spouse/domestic partner-employee.
- Groups with only partners and/or partners' spouse/domestic partner-employee.
- Carve-out groups (see "Section IV: New Business Submission Requirements" for the exception for employers of union and nonunion employees on page 16).
- Associations, multiplayer trusts, union trust plans, Taft-Hartley groups, retirees, and hour bank groups.

Blue Shield defines these groups as follows:

- **Association** – A group of employer units that are banded together for any reason, unless the group meets the definition of a guaranteed association.
- **Multiple Employer Trust** – Employers, usually in the same or related industries, that are brought together by an insurer, agent, broker, or administrator for the purpose of providing insurance for their employees under a master contract issued to a trustee under a trust agreement.
- **Union trust plans** – When a small group employer is contributing to a labor fund in compliance with a collective bargaining agreement for the purchase of healthcare benefits, that employer's union employees are considered ineligible for Blue Shield purposes.
- **Retirees** – Retirees are individuals who are former employees, typically over age 65, who may be eligible for retiree benefits if offered by the employer.
- **Taft-Hartley** – A group in a trust established under the authority of the Labor Management Relations Act of 1948. It comprises one or more unions and one or more employers that provide coverage for union members. A group contract is issued to the trustees named under the trust agreement, which usually results from collective bargaining.
- **Hour bank group** – A Taft-Hartley Welfare Fund in which eligibility under the fund is determined by a specific number of hours worked. If an employee works more hours

than is needed to maintain eligibility, the employee can put all or a portion of these excess hours in the bank. If an employee works insufficient hours to maintain eligibility, the employee can draw on banked hours.

- Other classifications that do not qualify as a small employer include private households, employees providing contracted services (i.e., receiving 1099 forms for income tax purposes), leased employees or employees part of a co-employment or PEO relationship, domestic help, and members of organizations (such as credit unions or fraternal order member organizations). Please see the Professional Employer Organization (PEO) section on page 17 for eligibility information concerning leased employees or employees that are part of co-employer relationship.

Other employer requirements

- The group agrees to inform its employees of the availability of coverage.
- The group must inform its employees who refuse coverage that, unless they qualify for late or special enrollment, as described below, they must wait until their group's next anniversary date to obtain coverage (see "Late enrollee" and "Special enrollment period").
- There can be only one employer group per group agreement/policy. Multiple employer groups that meet the definition of a single employer under California Health and Safety Code are counted as a single group. This means that owners of multiple businesses may not combine those businesses under a single Blue Shield agreement, unless they are eligible to file a combined tax return for the purposes of state taxation, meeting the definition of one employer as defined in California Health and Safety Code.
- The group's headquarters must be located in California.

Employer dues/premium contribution requirements

Medical benefits:

- The employer must contribute either (1) a defined contribution of a minimum $100 per employee (or the cost of the total employee rates, whichever is less), or (2) a minimum of 50% of the total employee rates.
- The employer may contribute the same amount for all employees or a maximum of two differing amounts based on employee classification. Contributions must meet the minimum requirement (above) and comply with the group contract.
- The employer must agree to make the required premium payments.
- There is no minimum contribution requirement for dependents.
- Payroll deduction is required if contributory.

New group eligibility/effective date

- For a group enrollment received on the first through the 15th day of any month, the coverage effective date must be no later than the first day of the following month.
- For a group enrollment received on the 16th through the last day of any month, the coverage effective date must be no later than the first day of the second following month.
- A small employer may opt for a later effective date, as long as it is within a quarter for which small group market rates are available.
- The eligibility date for existing employees and dependents is the group's effective date, unless new hires have not yet satisfied their group-imposed waiting period.
- Once rates are quoted to the employer group, the employer then has 30 days in which to accept coverage at the quoted rates. Once accepted, the employer can opt to change Blue Shield plan contracts to a different plan of benefits during the first 30 days after the group's effective date.
- However, once quoted rates are accepted by a group, the group cannot cancel coverage without being considered a canceled or terminated group.
- The employer has the option, at initial group enrollment only, to waive the waiting period for all new hires.
- Groups will not be guaranteed an effective date unless complete and correct group enrollment materials are received and approved by Blue Shield.

Orientation and waiting periods

An employer may impose a bona fide employment-based orientation (affiliation) period for new employees. The orientation period cannot

exceed 30 days. A waiting period may also be imposed before coverage becomes effective. The waiting period begins the first day after any orientation period and cannot exceed 90 days.

- A group may impose its own waiting period.
- The waiting period may be waived for all employees for the initial group enrollment.
- Blue Shield will administer the same waiting period for all employees or a maximum of two differing waiting periods based on employee classification.
- Waiting periods must comply with the requirements of Section 2708 of the ACA, and California state law, and any rules and regulations implementing those requirements.
- The employer must notify Blue Shield of the waiting periods it has in place, which are consistent with the following four options:
  - Effective the first day of the month following the date of hire
  - Effective the first day of the month following 30 days from the date of hire
  - Effective the first day of the month following 60 days from the date of hire
  - Effective on the 91st day following the date of hire. When the 91st day effective date results in a partial month of coverage, that partial month of coverage will be reflected on the employer's next monthly bill.

Additional enrollment and plan criteria

Special enrollment period for small groups

New group applications received between November 15 and December 15 requesting a January 1 effective date are eligible for coverage without meeting the minimum participation and contribution requirements.

- The group must meet all other small group eligibility requirements, **and**
- The group must meet the minimum participation requirements upon renewal to continue coverage.

HMO service area

- To offer HMO plans, the employer's place of business must be located in that Blue Shield HMO plan's service area.
- HMO plans are not designed to provide coverage for employees who reside outside California.
- Employees must live or work within the HMO plan's service area. Therefore, employers with employees who reside or work more than six months outside California should consider a PPO plan.
- With an HMO plan, eligible employees and family members must live or work in an area served by the Blue Shield HMO plan to enroll and maintain enrollment, except students, long-term travelers, and workers on extended out-of-state assignments enrolled in the Away From Home Care® program.
- The Blue Shield HMO service area is identified in the *HMO Physician and Hospital Directory*.
- Each enrolled employee and dependent must have a designated primary care physician (PCP). Each member may select a different PCP, as long as each provider is located adequately close to the member's home or work address to ensure access to care as determined by Blue Shield, unless the PCP is virtual.

HMO provider networks and pairing options

Off-Exchange Package for Small Business

In the Off-Exchange Package, three HMO provider networks are offered. Every HMO plan is available as an Access+ HMO® plan, a Local Access+ HMO® plan, or a Trio HMO plan.

- Access+ HMO®, Local Access+ HMO®, and Trio HMO plans may be offered together.
- Access+ HMO®, Local Access+ HMO®, and Trio HMO plans may be offered alongside Blue Shield small group PPO plans.

Mirror Package for Small Business

In the Mirror Package, two HMO provider networks are offered. HMO plans are available in the Access+ HMO® Network and in the Trio ACO HMO Network.

- Access+ HMO® plans and Trio HMO plans may be offered together.

Access+ HMO® Network (Off-Exchange Package for Small Business and Mirror Package for Small Business)

The Access+ HMO® Network, available with the Access+ HMO® plans, is the largest HMO provider network offered by Blue Shield. The Access+ HMO® plans are available in portions of El

Dorado, Kern, Monterey, Nevada, Placer, and San Bernardino counties, as well as all of Alameda, Butte, Contra Costa, Fresno, Imperial, Kings, Los Angeles, Madera, Marin, Merced, Orange, Riverside, Sacramento, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Ventura, and Yolo counties.

- A group must be located in the Access+ HMO® plan service area to select an HMO plan with the Access+ HMO® Network.
- The following HMO plans with the Access+ HMO® Network are available in the **Off-Exchange Package**:
    - Platinum Access+ HMO® 0/20 OffEx
    - Platinum Access+ HMO® 0/25 OffEx
    - Platinum Access+ HMO® 0/30 OffEx
    - Gold Access+ HMO® 0/35 OffEx
    - Gold Access+ HMO® 500/35 OffEx
    - Gold Access+ HMO® 1000/35 OffEx
    - Gold Access+ HMO® 1500/35 OffEx
    - Silver Access+ HMO® 2100/70 OffEx
    - Silver Access+ HMO® 2850/70 OffEx
    - Bronze Access+ HMO® 7000/65 OffEx
- The following HMO plans with the Access+ HMO® Network are available in the **Mirror Package**:
    - Blue Shield Access+ Platinum 90 HMO® 0/20 PCP + Child Dental
    - Blue Shield Access+ Gold 80 HMO® 250/35 PCP + Child Dental
    - Blue Shield Access+ Silver 70 HMO® 2500/55 PCP + Child Dental

Trio ACO HMO Network (Off-Exchange Package for Small Business and Mirror Package for Small Business)

The Trio ACO HMO Network is a collaboration among physicians, hospitals, and Blue Shield to help improve the patient experience and lower cost. "ACO" stands for accountable care organization. In addition to access to the Trio ACO HMO Network of in-person physicians, Trio HMO plan members have access to virtual care provided through Accolade Care, and the option to select a virtual PCP.

The Trio HMO plans are available in portions of El Dorado, Fresno, Kern, Kings, Los Angeles, Marin, Monterey, Nevada, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, Solano, Stanislaus, Tulare, Ventura, and Yolo counties, as well as all of Alameda, Contra Costa, Orange, San Francisco, San Joaquin, San Mateo, Santa Clara, and Santa Cruz counties. The Trio ACO Network is the second largest HMO provider network offered by Blue Shield.

- A group must be located in the Trio HMO plan service area to select an HMO plan with the Trio ACO HMO Network.
- The following HMO plans with the Trio ACO HMO Network are available in the **Off-Exchange Package**:
    - Platinum Trio HMO 0/20 OffEx
    - Platinum Trio HMO 0/25 OffEx
    - Platinum Trio HMO 0/30 OffEx
    - Gold Trio HMO 0/35 OffEx
    - Gold Trio HMO 500/35 OffEx
    - Gold Trio HMO 1000/35 OffEx
    - Gold Trio HMO 1500/35 OffEx
    - Silver Trio HMO 2100/70 OffEx
    - Silver Trio HMO 2850/70 OffEx
    - Bronze Trio HMO 7000/65 OffEx
- The following HMO plans with the Trio ACO HMO Network are available in the **Mirror Package**:
    - Blue Shield Trio Platinum 90 HMO 0/20 PCP + Child Dental
    - Blue Shield Trio Gold 80 HMO 250/35 PCP + Child Dental
    - Blue Shield Trio Silver 70 HMO 2500/55 PCP + Child Dental
    - Blue Shield Trio Bronze 60 HMO 7000/65 PCP + Child Dental Alt

Local Access+ HMO® Network (Off-Exchange Package for Small Business only)

The Local Access+ HMO® Network is a smaller subset of the Access+ HMO® Network and is the smallest HMO provider network offered by Blue Shield. It features a network of physicians available in portions of Contra Costa, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Mateo, and Ventura counties, as well as in all of Marin, Orange, San Francisco, San Luis Obispo, Santa Clara, Santa Cruz, Sonoma, Stanislaus, and Yolo counties.

- A group must be located in the Local Access+ HMO® plan service area to select an HMO plan with the Local Access+ HMO® Network.
- HMO plans with the Local Access+ HMO® Network are available in the **Off-Exchange Package**. The Local Access+ HMO® plans are:

- Platinum Local Access+ HMO® 0/20 OffEx
- Platinum Local Access+ HMO® 0/25 OffEx
- Platinum Local Access+ HMO® 0/30 OffEx
- Gold Local Access+ HMO® 0/35 OffEx
- Gold Local Access+ HMO® 500/35 OffEx
- Gold Local Access+ HMO® 1000/35 OffEx
- Gold Local Access+ HMO® 1500/35 OffEx
- Silver Local Access+ HMO® 2100/70 OffEx
- Silver Local Access+ HMO® 2850/70 OffEx
- Bronze Local Access+ HMO® 7000/65 OffEx

PPO provider networks and pairing options

Off-Exchange Package for Small Business

In the Off-Exchange Package, two PPO provider networks are offered: the Full PPO Network and the Tandem PPO Network.

- Full PPO and Tandem PPO plans may be offered together.
- Full PPO and Tandem PPO plans may be offered with Access+ HMO® plans, Local Access+ HMO® plans, and Trio HMO plans.

Mirror Package for Small Business

In the Mirror Package, all PPO plans are Full PPO Network plans.

Tandem PPO Network (Off-Exchange Package for Small Business only)

Blue Shield's Tandem PPO plans feature a select statewide network of providers from our Full PPO network and offer the same benefits as the Full PPO plan at a lower cost. Like other PPO plans, Tandem offers members the flexibility to see any doctor or specialist in the Tandem network without a referral. The Tandem PPO plan also features care coordination through a primary care physician. A list of providers in the Tandem PPO Network is available on the Blue Shield of California member website.

- PPO plans with the Tandem PPO Network are available in the Off-Exchange Package. The Tandem PPO plans are:
  - Platinum Tandem PPO 0/0 OffEx
  - Platinum Tandem PPO 0/10 OffEx
  - Platinum Tandem PPO 250/10 OffEx
  - Platinum Tandem PPO 250/15 OffEx
  - Virtual Blue℠ Platinum Tandem PPO 250/20 OffEx
  - Gold Tandem PPO 0/35 OffEx
  - Gold Tandem PPO 500/30 OffEx
  - Gold Tandem PPO 750/35 OffEx
  - Gold Tandem PPO 1000/30 OffEx
  - Virtual Blue℠ Gold Tandem PPO 1500/45 OffEx
  - Gold Tandem PPO Savings 1850/15% HDHP PrevRx OffEx
  - Silver Tandem PPO 1800/65 OffEx
  - Silver Tandem PPO Savings 2300/30% OffEx
  - Silver Tandem PPO 2100/75 OffEx
  - Silver Tandem PPO 2550/75 OffEx
  - Silver Tandem PPO Savings 2800/35% HDHP PrevRx OffEx
  - Virtual Blue℠ Silver Tandem PPO 2850/75 OffEx
  - Bronze Tandem PPO 4500/65 OffEx
  - Bronze Tandem PPO Savings 5700/40% OffEx
  - Bronze Tandem PPO 6250/65 OffEx
  - Bronze Tandem PPO 6500/70 OffEx
  - Bronze Tandem PPO 6850/55 OffEx
  - Bronze Tandem PPO Savings 7500 OffEx
  - Bronze Tandem PPO 7500/65 OffEx
  - Virtual Blue℠ Bronze Tandem PPO 7500/75 OffEx

Account-based health plans (Off-Exchange Package for Small Business and Mirror Package for Small Business)

An account-based health plan (ABHP) pairs a group health insurance plan with a tax-advantaged medical spending account. Blue Shield of California offers HSA-compatible high-deductible health plans (HDHP) that may be bundled with a health savings account (HSA) from HealthEquity, a health account administrator. When a group offers HealthEquity as the HSA administrator by indicating this selection on the Master Group Application, Blue Shield of California shares eligibility and claims data with HealthEquity for a seamless experience.

In the **Off-Exchange Package**, HSA-compatible high deductible health plans that may be bundled with an HSA from HealthEquity are:

- Gold Full PPO Savings 1850/15% HDHP PrevRx OffEx
- Gold Tandem PPO Savings 1850/15% HDHP PrevRx OffEx
- Silver Full PPO Savings 2300/30% OffEx
- Silver Tandem PPO Savings 2300/30% OffEx

- Silver Full PPO Savings 2800/35% HDHP PrevRx OffEx
- Silver Tandem PPO Savings 2800/35% HDHP PrevRx OffEx
- Bronze Full PPO Savings 5700/40% OffEx
- Bronze Tandem PPO Savings 5700/40% OffEx
- Bronze Full PPO Savings 7500 OffEx
- Bronze Tandem PPO Savings 7500 OffEx

In the **Mirror Package**, HSA-compatible high deductible health plans that may be bundled with an HSA from HealthEquity are:

- Blue Shield Silver 70 HDHP PPO 2300/30% PCP + Child Dental Alt
- Blue Shield Bronze 60 HDHP PPO 7500/0% PCP + Child Dental Alt

A group may offer one or more account-based health plans but cannot offer a mix of standalone account-based health plans and account-based health plans bundled with a HealthEquity HSA.

When a group selects the bundled option, employees cannot enroll in a standalone account-based health plan.

Additional benefits available

- An optional assisted reproductive technology benefits rider is available for PPO and HMO plans in the Off-Exchange Package and the Mirror Package.
  - When a group selects the optional assisted reproductive technology benefits rider, it will be included in all PPO and HMO plans offered by the group.
- A dental contract/policy is available with or without a health plan.
- A Blue Shield of California Life & Health Insurance Company vision policy is available with or without a health plan.
- A Blue Shield of California Life & Health Insurance Company Basic Life and AD&D insurance policy is available with or without a health plan.

Blue Shield of California Off-Exchange Package for Small Business

The Off-Exchange Package is available for groups with one or more enrolling employees.

- Plans in the Off-Exchange Package cannot be offered with plans from the Mirror Package.

Groups may select one or more plans from the package that includes:

- Platinum Access+ HMO® 0/20 OffEx
- Platinum Trio HMO 0/20 OffEx
- Platinum Local Access+ HMO® 0/20 OffEx
- Platinum Access+ HMO® 0/25 OffEx
- Platinum Trio HMO 0/25 OffEx
- Platinum Local Access+ HMO® 0/25 OffEx
- Platinum Access+ HMO® 0/30 OffEx
- Platinum Trio HMO 0/30 OffEx
- Platinum Local Access+ HMO® 0/30 OffEx
- Platinum Full PPO 0/0 OffEx
- Platinum Tandem PPO 0/0 OffEx
- Platinum Full PPO 0/10 OffEx
- Platinum Tandem PPO 0/10 OffEx
- Platinum Full PPO 250/10 OffEx
- Platinum Tandem PPO 250/10 OffEx
- Platinum Full PPO 250/15 OffEx
- Platinum Tandem PPO 250/15 OffEx
- Virtual Blue℠ Platinum Tandem PPO 250/20 OffEx
- Gold Access+ HMO® 0/35 OffEx
- Gold Trio HMO 0/35 OffEx
- Gold Local Access+ HMO® 0/35 OffEx
- Gold Access+ HMO® 500/35 OffEx
- Gold Trio HMO 500/35 OffEx
- Gold Local Access+ HMO® 500/35 OffEx
- Gold Access+ HMO® 1000/35 OffEx
- Gold Trio HMO 1000/35 OffEx
- Gold Local Access+ HMO® 1000/35 OffEx
- Gold Access+ HMO® 1500/35 OffEx
- Gold Trio HMO 1500/35 OffEx
- Gold Local Access+ HMO® 1500/35 OffEx
- Gold Full PPOSil 0/35 OffEx
- Gold Tandem PPO 0/35 OffEx
- Gold Full PPO 500/30 OffEx
- Gold Tandem PPO 500/30 OffEx
- Gold Full PPO 750/35 OffEx
- Gold Tandem PPO 750/35 OffEx
- Gold Full PPO 1000/30 OffEx
- Gold Tandem PPO 1000/30 OffEx
- Virtual Blue℠ Gold Tandem PPO 1500/45 OffEx
- Gold Full PPO Savings 1850/15% HDHP PrevRx OffEx
- Gold Tandem PPO Savings 1850/15% HDHP PrevRx OffEx
- Silver Access+ HMO® 2100/70 OffEx
- Silver Trio HMO 2100/70 OffEx

- Silver Local Access+ HMO® 2100/70 OffEx
- Silver Access+ HMO® 2850/70 OffEx
- Silver Trio HMO 2850/70 OffEx
- Silver Local Access+ HMO® 2850/70 OffEx
- Silver Full PPO 1800/65 OffEx
- Silver Tandem PPO 1800/65 OffEx
- Silver Full PPO Savings 2300/30% OffEx
- Silver Tandem PPO Savings 2300/30% OffEx
- Silver Full PPO 2100/75 OffEx
- Silver Tandem PPO 2100/75 OffEx
- Silver Full PPO 2550/75 OffEx
- Silver Tandem PPO 2550/75 OffEx
- Silver Full PPO Savings 2800/35% HDHP PrevRx OffEx
- Silver Tandem PPO Savings 2800/35% HDHP PrevRx OffEx
- Virtual Blue℠ Silver Tandem PPO 2850/75 OffEx
- Bronze Access+ HMO® 7000/65 OffEx
- Bronze Trio HMO 7000/65 OffEx
- Bronze Local Access+ HMO® 7000/65 OffEx
- Bronze Full PPO 4500/65 OffEx
- Bronze Tandem PPO 4500/65 OffEx
- Bronze Full PPO Savings 5700/40% OffEx
- Bronze Tandem PPO Savings 5700/40% OffEx
- Bronze Full PPO 6250/65 OffEx
- Bronze Tandem PPO 6250/65 OffEx
- Bronze Full PPO 6500/70 OffEx
- Bronze Tandem PPO 6500/70 OffEx
- Bronze Full PPO 6850/55 OffEx
- Bronze Tandem PPO 6850/55 OffEx
- Bronze Full PPO Savings 7500 OffEx
- Bronze Tandem PPO Savings 7500 OffEx
- Bronze Full PPO 7500/65 OffEx
- Bronze Tandem PPO 7500/65 OffEx
- Virtual Blue℠ Bronze Tandem PPO 7500/75 OffEx

Off-Exchange Package for Small Business participation requirements

The group must maintain the required minimum participation requirements set forth below to remain eligible (or 100% participation, if non-contributory). Groups are subject to non-renewal if participation falls below the required minimum.

- Under the Off-Exchange Package, when Blue Shield is the only carrier offered, a minimum of one eligible employee and at least 65% of all eligible employees must enroll in the Blue Shield plan(s).

  If Blue Shield is offered alongside another carrier's small group HMO, or MediExcel or SIMNSA and another carrier's small group HMO, a minimum participation of 65% between all carriers is required and, in the combination of Blue Shield plans, the participation must be equal to the greater of five enrolled employees or 50% of the total number of enrolled employees.
- 100% contribution/participation requirements:
  - If the group contributes 100% of dues/premium, then 100% of eligible employees must enroll (except those waiving due to group coverage through another employer).
- Declining or waiving coverage:
  - A Refusal of Coverage form (C19927) is required if refusing coverage with Blue Shield due to coverage with another carrier through a different employer. Refusals of coverage in this instance are not counted toward the participation requirement.
  - A Refusal of Coverage form (C19927) is required if refusing coverage with Blue Shield due to coverage with another carrier through the same employer. Refusals of coverage in this instance are counted toward the participation requirement.
  - If an eligible employee and spouse or domestic partner both work for the same employer, they may enroll separately as employees, or one may enroll as a dependent on the other's coverage. Any child(ren) of such persons may be enrolled as the dependent(s) of either employee, but not both.

Off-Exchange Package for Small Business notes:

- Employers whose place of business is located outside of one of Blue Shield of California's HMO service areas will not have the option of offering an HMO plan within the Off-Exchange Package.
- If a group selects the Off-Exchange Package, it may make one or more plan options available to eligible employees by indicating

its selected plans on the Master Group Application. There is no requirement for an employee to be enrolled in each of the plans selected and made available as options for employees.
- The Off-Exchange Package plans can be offered alongside another carrier's small group plans.
- A plan in the Off-Exchange Package may be offered as a single option plan.

Blue Shield of California Mirror Package for Small Business

The Mirror Package is available for groups with one or more enrolling employees.

Plans in the Mirror Package cannot be offered with plans from the Off-Exchange Package.

Groups may select one or more plans from the package that includes:

- Blue Shield Platinum 90 PPO 0/15 PCP + Child Dental
- Blue Shield Gold 80 PPO 350/25 PCP + Child Dental
- Blue Shield Silver 70 PPO 2500/55 PCP + Child Dental
- Blue Shield Bronze 60 PPO 5800/60 PCP + Child Dental
- Blue Shield Silver 70 HDHP PPO 2300/30% PCP + Child Dental Alt
- Blue Shield Bronze 60 HDHP PPO 7500/0% PCP + Child Dental Alt
- Blue Shield Access+ Platinum 90 HMO® 0/20 PCP + Child Dental
- Blue Shield Access+ Gold 80 HMO® 250/35 PCP + Child Dental
- Blue Shield Access+ Silver 70 HMO® 2500/55 PCP + Child Dental
- Blue Shield Trio Platinum 90 HMO 0/20 PCP + Child Dental
- Blue Shield Trio Gold 80 HMO 250/35 PCP + Child Dental
- Blue Shield Trio Silver 70 HMO 2500/55 PCP + Child Dental
- Blue Shield Trio Bronze 60 HMO 7000/65 PCP + Child Dental Alt

Mirror Package for Small Business participation requirements

The group must maintain the required minimum participation requirements set forth below to remain eligible (or 100% participation, if non-contributory). Groups are subject to non-renewal if participation falls below the required minimum.

- Under the Mirror Package, a minimum of one eligible employee and at least 65% of all eligible employees must enroll in the Blue Shield plan(s).
- If Blue Shield is offered alongside another carrier's small group HMO, or MediExcel or SIMNSA and another carrier's small group HMO, a minimum participation of 65% between all carriers is required and, in the combination of Blue Shield plans, the participation must be equal to the greater of five enrolled employees or 50% of the total number of enrolled employees.
- 100% contribution/participation requirements:
  - If the group contributes 100% of dues/premium, then 100% of eligible employees must enroll (except those waiving due to group coverage through another employer).
- Declining or waiving coverage:
  - A Refusal of Coverage form (C19927) is required if refusing coverage with Blue Shield due to coverage with another carrier through a different employer. Refusals of coverage in this instance are not counted toward the participation requirement.
  - A Refusal of Coverage form (C19927) is required if refusing coverage with Blue Shield due to coverage with another carrier through the same employer. Refusals of coverage in this instance are counted toward the participation requirement.
  - If an eligible employee and spouse or domestic partner both work for the same employer, they may enroll separately as employees, or one may enroll as a dependent on the other's coverage. Any child(ren) of such persons may be enrolled as the dependent(s) of either employee, but not both.

Mirror Package for Small Business notes:

- The employer's place of business must be located in the Trio HMO plan service area in order to offer Trio HMO plans from the Mirror Package.

- The employer's place of business must be located in the Access+ HMO® plan service area in order to offer Access+ HMO® plans from the Mirror Package.
- If a group selects the Mirror Package, it may make one or more plan options available to eligible employees by indicating its selected plans on the Master Group Application. There is no requirement for an employee to be enrolled in each of the plans selected and made available as options for employees.
- The Mirror Package plans can be offered alongside another carrier's small group plans.
- A plan in the Mirror Package may be offered as a single option plan.

Section II: Who can enroll?

Employee eligibility for coverage ("eligible employee")

The following criteria determine if an individual is an "eligible employee" and is eligible for enrollment in the group health plan:

- He/she works on a full-time basis in the conduct of the business of the employer, whose normal work week is an average of 30 hours, and whose duties in such employment are performed at the employer's regular places of business (subject to withholding on a W-2 form), **or**

  He/she is a sole proprietor, spouse or domestic partner of a sole proprietor, corporate officer, partner of a partnership, or the spouse or domestic partner of a partner of a partnership engaged on a full-time basis, an average of 30 hours per week, in the employer's regular places of business and the group meets all small employer eligibility requirements.
- He/she works at least 20 hours, but no more than 29 hours, per week, in the employer's business on a permanent, year-round basis and meets the individual employee criteria, as defined within California Health and Safety Code for an eligible part-time employee.
- He/she receives monetary compensation (W-2 employee) for that work by the employer.
- He/she is a bona fide employee of the employer (a bona fide employee/employer relationship must exist).
- He/she has met any applicable employer-imposed eligibility waiting period.

The following individuals are *not* considered "eligible employees" and are not eligible for coverage:

- Residents of Hawaii
- Retirees
- Part-time (unless offered by the employer and meets the requirements of an eligible part-time employee), temporary, substitute, or seasonal employees (seasonal or substitute employees are defined as employees hired with a planned future termination date)
- 1099 independent contractors
- Domestic help
- Employees participating in a multiple employer group
- Leased employees or employees who are part of a co-employment or PEO relationship (see PEO section for leased employees or employees that are part of a co-employer relationship)
- Employees living outside of the United States

Part-time employee eligibility for coverage

All guidelines that apply to full-time employees also apply to part-time employees (PTEs) with these additional guidelines:

- The PTE must work a minimum of 20 hours per week to be eligible. The employee must have worked at least 20 hours, but not more than 29 hours, per normal work week, for at least 50% of the working days in the previous calendar quarter.
- It is the employer's option to offer health coverage to PTEs. If that option is exercised, all similarly situated individuals must be offered coverage under the employer's benefit plan.
- The employer benefit choice (which may include dental and/or vision plans) must match the coverage given to full-time employees.
- Participation requirements are based on the total number of PTEs and full-time employees.
- To add PTE eligibility to an existing account, we require a completed and signed Group

Change Request and applications/ declinations for all eligible PTEs.

- Existing groups may add this option at any time during the year. If the option is added off-anniversary, it will be effective on the first of the month following receipt of the request.
- Blue Shield may require information necessary to document the hours and time periods of PTEs, including, but not limited to, payroll records and employee wage and tax filings.

NOTE: If the above criteria are met for health coverage, then life insurance coverage can be written for eligible PTEs.

Dependent eligibility for coverage

Dependent coverage is available to the following individuals:

- An employee's legally married spouse who is not covered for benefits as an employee and is not legally separated from the employee
- An employee's domestic partner who is not covered for benefits as an employee
- An employee's, spouse's, or domestic partner's child (including any stepchild or child placed for adoption or any other child for whom the employee or domestic partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction) who is not covered for benefits as a subscriber and who is less than 26 years of age
- An employee's, spouse's, or domestic partner's newborn child, if added to an existing policy within 60 days following the date of birth
- Overage disabled dependents
  - Enrolled dependent children who would normally lose their eligibility under the Blue Shield of California small business plan solely because of age, but who are disabled by reason of a physically or mentally disabling injury, illness, or condition may have their eligibility extended by written application within 31 days of the date the dependent child reaches the age eligibility would otherwise cease.
  - To qualify for this extension, the disabled dependent child must be incapable of self-sustaining employment and be chiefly dependent upon the subscriber for support and maintenance.
  - A completed medical certification of disability, the Declaration of Disability for Overage Dependent Child, must be submitted.
  - A recertification of disability may be required within two years after the initial medical certification and annually thereafter, except in cases of long-term disability.
  - If the parent or guardian and dependent have **not** been covered by a Blue Shield of California health plan prior to the age that dependent eligibility ceases, evidence/proof of prior dependent coverage will be required in addition to the medical certification of disability and application.

Domestic partners

Eligibility for registered domestic partners is a mandated benefit for all Blue Shield group health plans. To qualify as a "dependent," a domestic partner is an individual who is personally related to the subscriber by a domestic partnership that meets the following requirements:

- Both partners are 18 years of age or older, except as provided in Section 297.1 of the California Family Code;
- The partners have chosen to share an intimate and committed relationship of mutual caring;
- The partners are (a) not currently married to someone else or a member of another domestic partnership, and (b) not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited;
- Both partners are capable of consenting to the domestic partnership; and
- The partners have filed a Declaration of Domestic Partnership with the Secretary of State. (Note, some employers may permit partners who meet the above criteria but have not filed a Declaration of Domestic Partnership with the Secretary of State to be eligible for coverage as a Domestic Partner under the Plan. If permitted by the employer, such individuals are included in the term "Domestic Partner" as used in the Evidence of Coverage; however, the partnership may not be recognized by the State for other purposes as the partners do not meet the definition of "Domestic Partner" established under Section 297 of the California Family Code).

The domestic partnership is deemed created on the date when both partners meet the above requirements.

Spouses or domestic partners working for the same employer

If spouses or domestic partners both work for the same employer, they may enroll separately as employees, or one may enroll as a dependent on the other's coverage. They cannot enroll in a plan as both subscriber and dependent, and when the group offers more than one product such as medical and dental, they cannot enroll as subscriber in one product and as dependent in another.

Any children of such persons may be enrolled as the dependents of either employee, but not both.

Children working for the same employer

If children of an employee work for the same employer, they may enroll separately as employees, or if eligible they may enroll as dependents on the parent-employee's coverage. They cannot enroll in a plan as both subscriber and dependent, and when the group offers more than one product such as medical and dental, they cannot enroll as subscriber in one product and as a dependent in another.

Section III: Health Plan Rating Criteria

Quoting a group – Field rating

A field-rating tool is available to producers, to allow quick and easy online rating for small employer groups. The rating tool is available at **blueshieldca.com/producer**.

- Group monthly premiums are calculated based on the subscribers' ages and the employer's principal business address as of the first day of the month.
- Composite rating is not available.
- Before submitting an application for a group, please review the requirements under "Submitting an application" and "Certifying your compliance" on page 30.

Rating policies

- All rates will be based on actual enrollment.
- Final rates, effective date, and acceptability of the group will be determined by Blue Shield.
- Approved out-of-state employees will be charged an area rate based on the location of the employer's principal business address in California.

Medicare primary and secondary rules

For employers who are subject to federal Medicare secondary payer laws, Medicare entitlement is currently based on three basic situations and depends on group size. The three situations are:

1. **Medicare entitlement based on age (65 or older)**

For groups with an average of 20 or more full- and/or part-time total employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year, Blue Shield commercial coverage will be the primary payer to Medicare for active employees ages 65 or older and the spouses (ages 65 or older) of active employees.

2. **Medicare entitlement based on disability**

For groups (not part of a multi-employer plan) with an average of fewer than 100 employees in the prior calendar year, Medicare is the primary payer to the employer group's commercial plan for active employees and dependents of active employees who are entitled to Medicare based on disability. For groups that employ 100 or more full-, part-time, or temporary employees 50% or more business days of the previous calendar year, Blue Shield commercial coverage is the primary payer.

3. **Medicare entitlement based solely on end-stage renal disease (ESRD)**

Regardless of group size or current working requirement, if a group offers employees, or former employees under age 65, an employee group plan, Blue Shield commercial coverage will be the primary payer to Medicare during the 36-month coordination period that begins with the month of Medicare entitlement. The coordination period is 30 months with a three-month waiting period (for a possible total coordination period of 36 months). The three-month waiting period is waived if the member has a transplant or home dialysis. Then the coordination period is only 30 months.

More complex situations (such as Medicare dual entitlement) do arise. If you have any questions

concerning Medicare entitlement for groups offering Blue Shield commercial plans, please contact Blue Shield for further guidance.

Blue Shield Medicare Supplement plans

Blue Shield also provides a variety of standardized Medicare Supplement plans on an individual basis. Medicare-eligible employees have the freedom to choose any Medicare-participating doctor or hospital, although benefits and dues vary. For more information on Blue Shield Medicare Supplement plans, please contact your Blue Shield representative or call (800) 963-8008.

Rate changes

The group's rate will not change more often than every 12 months.

Section IV: New Business Submission Requirements

Guidelines for completing forms

To ensure fast and accurate application processing, follow these enrollment application guidelines:

All questions must be answered and all signatures and dates obtained before we can begin processing the group applications. If the appropriate applications and related documents are incomplete and Blue Shield cannot begin processing, Blue Shield retains the option of returning all paperwork – the applications and the supporting documents – to the producer.

For new group submissions, the employee's signature cannot be dated more than 90 days prior to the requested effective date. All answers on the enrollment applications must be in the employee's own handwriting.

- On the original employee application, no alterations or changes may be made by anyone other than the employee.
- Language assistance: Whenever an individual completing the application has a language barrier and requires assistance to properly complete the form, a signed Blue Shield Exception to Standard Enrollment Form from the group or the producer explaining the situation must accompany the submitted application.

Processing time specifications

- Because processing applications within specific time frames is important, all forms and other documents for evaluation should be accurately completed and included with the application when the case is first submitted to Blue Shield.
- Blue Shield can usually make a timely decision if all proper documentation is received with the initial submission. Please refer to the "New group enrollment checklist" on page 15 for a list of required documentation. Any missing documentation and/or dues will cause a delay in the process. Blue Shield will request additional information only when it is needed to accurately assess or verify the eligibility of the group and/or employee(s).
- Blue Shield must receive all completed paperwork by the 15th calendar day of the month when the requested effective date is for the first day of that month.

Evaluation criteria

Underwriting is based on the following criteria:

- Contribution
- Employee and dependent eligibility
- Participation

Please note that any employee/dependent accepted for a Blue Shield small group health plan cannot concurrently be covered under a Blue Shield individual contract. The applicant must elect, in writing, one or the other coverage to avoid duplicate Blue Shield coverage.

Blue Shield may decline groups if:

- No bona fide employer/employee relationship exists (i.e., independent contractors, leased employees, domestic help)
- Group is not a California-based employer
- Employer is not authorized to conduct business in California
- Group employed less than one common-law employee (W-2) or more than 100 employees on 50% of the workdays in the previous calendar quarter of the previous calendar year
- Group is a carve-out (see Section IV, "New Business Submission Requirements" for the exception for employers of union and nonunion employees on page 16)

- Group is otherwise not subject to California Health and Safety Code and the Affordable Care Act guidelines

Waivers/declinations

- If an employee is waiving coverage due to group coverage (either as a subscriber or a dependent), the employee may be considered ineligible for the purposes of calculating participation. The employer group must submit a declination form for these employees.
- Any eligible employee and/or dependent waiving coverage for any reason at the time of enrollment must complete the Refusal of Coverage section of the Employee Enrollment Form, and the employer must forward this information to Blue Shield.
- For employers offering more than one carrier, waivers are required for employees that are enrolling in another carrier's plan.

New group enrollment checklist

1. **Every new group** is required to submit the following:

- ☐ **Master Group Application** (either paper, Blue Shield MGA spreadsheet when used in conjunction with the Employee Enrollment spreadsheet, or online portal*)
- ☐ **Applications** from all enrolling employees and dependents (either paper, Blue Shield Employee Enrollment spreadsheet, or online portal*)
- ☐ **Refusal of Coverage forms** for all eligible employees and any eligible dependents who refuse or waive coverage at the time of open enrollment (either paper, Blue Shield Employee Enrollment spreadsheet, or online portal*)
- ☐ **Applications for COBRA or Cal-COBRA enrollees**, if available* (may be submitted later as maintenance)
- ☐ **First month's payment** on company check stock **or** the completed Small Group Initial Payment Form†
    - The Small Group Initial Payment Form is used for the initial payment for new group submissions only, and the initial payment must be a minimum of 70% of the anticipated first month's payment.
    - Blue Shield will refund the full deposit to the group if the group application is declined

*Employer/broker retains these forms when applying through the online portal or using the MGA and/or Employee Enrollment spreadsheet.

†Employer/Broker retains the Small Group Initial Payment Form when applying through the online portal.

2. New groups with **1 or 2 eligible employees or less than 3 Full-time and Full-time Equivalent (FT/FTE) employees or more than 95 FT/FTE employees** are required to submit the following additional documentation to verify eligibility. Blue Shield reserves the right to require this documentation for new groups with **3 or more eligible employees or 3 or more FT/FTE employees**.

- ☐ The group's **most recent DE9C Quarterly State Tax Withholding Statement***
- ☐ **Payroll register** for employees hired after the DE9C filing or if any employees are out of state†

* Groups in business and employing at least one eligible common-law employee for longer than 6 weeks but not long enough to file their first DE9C must submit their payroll register covering the preceding 6 weeks.
† If payroll is not yet available for employees hired after the DE9C was filed, submit their W-4s.

New groups with **1 or 2 eligible employees or less than 3 Full-time and Full-time Equivalent (FT/FTE) employees** are required to submit the following additional documentation based on the type of entity to verify group and owner eligibility. Blue Shield reserves the right to require this documentation for new groups with **3 or more eligible employees or 3 or more FT/FTE employees.**

Sole Proprietorship	1. Business license or other filed document confirming active status of the business 2. If group uses a DBA: DBA printed on the group's business check; **or** Fictitious Business Name (FBN) filing 3. If owner is enrolling or refusing coverage and is not listed on the DE9C: • Completed and signed Blue Shield of California Small Group Owner Eligibility Statement

Partnership, Limited Partnership (LP), Limited Liability Partnership (LLP)	1. Partnership Agreement 2. If owners are enrolling or refusing coverage and are not listed on the DE9C: • Completed and signed Blue Shield of California Small Group Owner Eligibility Statement for each owner not listed on the DE9C
Corporations	1. Statement of Information **or** Articles of Incorporation 2. If owners are enrolling or refusing coverage and are not listed on the DE9C: • Completed and signed Blue Shield of California Small Group Owner Eligibility Statement for each owner not listed on the DE9C
Limited Liability Company (LLC)	1. Statement of Information **or** Operating Agreement 2. If owners are enrolling or refusing coverage and are not listed on the DE9C: • Completed and signed Blue Shield of California Small Group Owner Eligibility Statement for each owner not listed on the DE9C
Nonprofit	1. Statement of Information 2. Nonprofit Corporation Bylaws 3. Additional documentation that may be required: • Nonprofit 990 EZ tax form • Board of Directors or shareholders meeting minutes 4. If officers, directors, and/or trustees are enrolling or refusing coverage and are not listed on the DE9C: • W-2

3. Groups in the following categories have unique documentation requirements that must be submitted when **one or more employees** are enrolling:

Employers of union and nonunion employees

For small employer groups with union and nonunion employees, when the union members receive health coverage through a trust fund established by a collective bargaining agreement, Blue Shield will cover only the nonunion employees.

When the total number of both union and nonunion employees does not exceed 100, the employer can apply for small group coverage to cover only the nonunion employees. Only the eligible nonunion employees will be counted for purposes of minimum enrollment and participation requirements. To qualify for this coverage, the employer must provide Blue Shield with the following additional documentation:

- ☐ Most recently filed DE9C and/or payroll register (payroll register required if any employees are out of state) with union and nonunion employees identified
- ☐ A copy of the collective bargaining agreement showing that the employer pays contributions to the trust fund
- ☐ The Statement of ERISA Rights from the union trust fund Summary Plan Description

Professional Employer Organization ("leased") employees

Professional Employer Organization (PEO or "leased") employees are considered employees of the PEO company. Small employer groups that have canceled their PEO arrangement and hired the former PEO employees will be considered for coverage as a qualified small employer pursuant to small group rules.

For small employer groups that have recently canceled their contract with a PEO, the following additional documentation is required:

- ☐ A copy of the letter sent from the PEO to the client business verifying the cancelation of the leasing arrangement
- ☐ A copy of a payroll register from the PEO company that separates the formerly leased employees by business location

Affiliated and subsidiary companies

When determining the number of employees or eligible employees a group employs, companies that are affiliated companies and that are eligible to file a combined state tax return are considered to be one employer.

A group that has affiliated/subsidiary companies that are eligible to file a combined state tax return is required to provide the following documentation when the group is not including one or more of the affiliated/subsidiary companies in the Blue Shield small group coverage:

- ☐ Ownership documentation for all eligible subsidiaries/affiliated companies
- ☐ Most recently filed DE9C and/or payroll register (payroll register required if any employees are out of state) for all eligible subsidiaries/affiliated companies
- ☐ Applications and Refusals of Coverage for employees of all eligible subsidiaries/affiliated companies

Spin-off groups

A "spin-off group" is a newly formed business that is not yet eligible for qualified small group coverage, and in which a majority of the employees of the new business have left an established business ("former business") currently offering Blue Shield coverage to its employees. A spin-off group must meet all small group requirements except for the length of time that the group has employed at least one eligible common-law employee who was covered under the former business's Blue Shield small group health plan.

The requirements for issuance of coverage are:

- At least 50% of the employees in the spin-off group must have been enrolled in Blue Shield through the former business
- The new group does not have shared ownership with the business it has separated from

A spin-off group must submit the following documentation:

- ☐ W-4 forms for all W-2 employees
- ☐ Blue Shield of California Start-up/Spin-off Companies Small Business Eligibility Statement completed and signed by one of the group's owners
- ☐ Blue Shield of California Small Business Owner Eligibility Statement completed and signed by any additional owners who are enrolling or refusing coverage
- ☐ Filed owner documentation linking owner to business
- ☐ All enrollment documents (employer and employee applications, refusals, Small Group Initial Payment Form or business check for first month's payment)

Startup groups

A startup group must meet all small group requirements except for the length of time that the group has employed at least one eligible common-law employee. Blue Shield will consider startup groups that have been in business and have employed at least one eligible common-law employee for less than six weeks.

A startup group must submit the following documentation:

- W-4 forms for all W-2 employees
- Blue Shield of California Start-up/Spin-off Companies Small Business Eligibility Statement completed and signed by one of the group's owners
- Blue Shield of California Small Business Owner Eligibility Statement completed and signed by any additional owners who are enrolling or refusing coverage
- Filed owner documentation linking owner to business
- All enrollment documents (employer and employee applications, refusals, Small Group Initial Payment Form or business check for first month's payment)

Section V: Existing Business Guidelines

Enrolling new hires

New eligible employees hired after the group's effective date are eligible for coverage after completing the employer's eligibility waiting period.

- For eligibility verification, wage information may be required.
- Effective dates are determined as follows:

  a) If the application is received by Blue Shield prior to the completion of the employee's waiting period, the effective date coincides with the eligibility date.

  b) If the application is received by Blue Shield after the eligibility date, the effective date is as follows:

  For enrollment received on the first through the 15th day of any month, the coverage effective date must be no later than the first day of the following month.

  For enrollment received on the 16th through the last day of any month, the coverage effective date must be no later than the first day of the second following month.

- For coverage declination, the Refusal of Coverage section of the Employee Enrollment Form must be completed any time an employee and/or dependent becomes eligible but does not enroll, or if the employee and/or dependent remains eligible but is not retaining coverage.
- Dependent special enrollment periods are provided for newborns, adoptees, and new spouses/domestic partners. These dependents may be added without a waiting period if they are enrolled within 60 days of becoming eligible. In addition, spouses/domestic partners who are eligible (but not enrolled) may also be added in the event of a birth or adoption. An employee who is eligible (but not enrolled) may enroll at the time of marriage/establishment of a domestic partnership, birth, adoption, or placement for adoption.

Enrolling late enrollees

Unless covered under an exception, "late enrollees" are generally defined as eligible employees or dependents who refused their employer's health plan coverage when they were first eligible to enroll and later request enrollment in their employer's Blue Shield health plan. Late enrollees must wait until their employer's next renewal date to obtain coverage. See the specific definition set forth in Section VII of these Underwriting Guidelines.

An eligible employee or dependent who refused their employer's health plan coverage when they were first eligible to enroll because they were enrolled in another employer's health benefit plan, and who requests enrollment after a loss of coverage under that other employer's health benefit plan and under certain conditions as set forth in the definition of "late enrollee" under Section VII, is not considered a "late enrollee." Such an employee or dependent must request enrollment within 60 days after his or her loss of that coverage and must also submit verification of that coverage. If enrollment is not requested within 60 days, the employee or dependent will be enrolled no later than the first day of the month beginning after the date the request for special enrollment was received.

Special enrollment period

When certain triggering events occur, an eligible employee can enroll himself or herself or any eligible dependents or change coverage during a defined special enrollment period. Dependent spouses and children cannot be enrolled prior to (or without) the employee being enrolled, with one exception: a court-ordered dependent may be enrolled without the employee being enrolled.

The employee generally has 60 days from the date of the triggering event to apply for coverage. The employee and his or her dependents have a special enrollment period when the employee or his or her dependents loses minimum essential coverage up to 60 days prior to and 60 days after termination of existing coverage. This allows the individual to transfer into new coverage without a coverage gap.

An eligible individual may enroll in a plan, or an enrollee may change plans, during special enrollment periods only if one of the qualifying/triggering events occurs. Refer to the group's *Evidence of Coverage* (EOC) for the

qualifying/triggering events and effective date rules.

Open enrollment

Employers are encouraged to hold an open enrollment period for their employees, to take place before each anniversary date of their Blue Shield plan. The open enrollment period gives eligible employees and their dependents the chance to make decisions regarding their coverage for the coming plan year.

During the open enrollment period, employees currently enrolled may transfer into any available employer-sponsored health plan.

Eligible employees and/or dependents who initially refused coverage and later elected to be added to a Blue Shield health plan can enroll during the next open enrollment period.

Guaranteed renewal

A group with an existing Blue Shield group health service contract is eligible for guaranteed renewal in accordance with the guaranteed renewability requirements of the ACA. Guaranteed renewability generally applies to an existing Blue Shield group if:

- It is a group of one or more common-law employees;
- It has made all required premium payments;
- Neither it nor its employees or dependents have committed fraud or misrepresentation;
- It continues to qualify as an employer in this state
- It continues to meet participation and contribution requirements; **and**
- It has otherwise maintained small group eligibility

A group is not eligible for guaranteed renewal if it does not meet all of the conditions above, or:

- The group moves out of the service area, **or**
- Its association membership through which it obtained Blue Shield plan coverage ceases

If eligible for guaranteed renewal, the group may select, upon renewal, any health plan Blue Shield offers to new small employer businesses.

Blue Shield reserves the right to obtain documents at each renewal to recertify that the group is an eligible small employer as defined in California Health and Safety Code and the federal Affordable Care Act.

Small-to-large group renewal conversions

Federal law now allows for a group to renew its existing Blue Shield small employer plan, even if the group has grown in size and is technically a large (101+ employees) employer. However, if the group decides not to renew its Blue Shield small employer plan, and instead applies for a Blue Shield large employer plan (and is accepted by Blue Shield), the group cannot later apply for a small employer plan.

Contract benefit modifications

Group level

Employer-requested health plan or contract changes can be effective only on the group's renewal date. Changes to add or delete specialty benefits coverage may be made at any time during the plan year.

Depending on the type of benefit modification requested, underwriting may be required. Certain supporting documentation is also required to review a request to modify benefits. The required documentation must be complete and accurate to process the request. Please also refer to the Benefit Modification Options exhibit on page 21 to determine when each type of benefit modification may be requested and to determine what documents must accompany your request.

Subscriber level

- Covered subscribers will be allowed to move to different products offered by their group at the anniversary month of the group's original effective date or at the time a group-level benefit change is approved by Blue Shield.
- A subscriber requesting a change in benefits must submit a Subscriber Change Request Form or standard application, Form or standard application, provided that the group is offering the plan.

Re-enrollees

Re-enrollees (see Section VII, "Definitions") must complete an Employee Enrollment Form.

Benefit Modification Options Chart

Benefit modification	When eligible	Necessary documents
Add medical benefits Includes: • Increasing number of plans offered under existing Blue Shield health coverage • Change in level of benefits offered under existing Blue Shield health coverage	On group's anniversary date	1. Small Business Group Change Request form 2. Subscriber Change Request form for those employees requesting to change
Add part-time employee eligibility	Any time during the year If the option is added off-anniversary, it will be effective on the first of the month following receipt of the request.	1. Small Business Group Change Request form 2. New applications or declinations on all eligible part-time employees
Remove part-time employee eligibility	On group's anniversary date	1. Small Business Group Change Request form 2. Most recently filed DE9C with all part-time employees identified 3. Reconciled payroll for employees who live outside of California 4. Reconciled payroll may be required when wages are high for part-time employees
Change to employer waiting period	On group's anniversary date	Small Business Group Change Request form

Section VI: Health Plan Benefit Continuity

Prior deductible credit

Blue Shield will credit the amount of the deductible satisfied for medical expenses under the benefit plan of the employer group's prior carrier in the same calendar year; however, there is no prior carrier deductible credit for outpatient prescription drug coverage. The employer's prior carrier information is provided by the employer on the Master Group Application. Prior deductible credit is available only for individuals enrolled in the group plan as of the initial effective date with Blue Shield. In addition, the individual must be enrolled in the same plan type (HMO plan, PPO/HSA-eligible HDHP plan) with Blue Shield as enrolled with the prior carrier.

Takeover provisions

Blue Shield small group takeover provisions comply with the following:

- Any carrier providing replacement health coverage within a period of 60 days from the date prior coverage is discontinued and which provided health coverage comparable to the new contract will be required to cover all employees and dependents who were both:
    1. Validly covered under the prior contract at the time the contract was discontinued, **and**
    2. Within the definitions of eligibility under the succeeding carrier's contract
- Such employees and dependents will be eligible regardless of any other provision within the succeeding carrier's contract relating to active full-time employment or pregnancy.
- However, with respect to employees or dependents who are totally disabled on the date of discontinuance of the prior contract and eligible for an extension of benefits under that contract, the succeeding carrier is not required to provide benefits directly related to any condition which caused the total disability.

(For more details, please refer to Section VIII, "State and Federal Regulations.")

Section VII: Definitions

Guaranteed associations defined

A guaranteed association:

- Is a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry
- Accepts any individual or employer for membership who meets its membership criteria
- Includes one or more small employers
- Does not make membership directly or indirectly conditional on the health or claims history of any person
- Uses membership dues solely for, and in consideration of, the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association
- Is organized and maintained in good faith for purposes unrelated to insurance
- Is in active existence on January 1, 1992, and has included health insurance as a membership benefit for at least five years prior to that date
- Is governed by a constitution and bylaws or other analogous governing documents that provide for election of the association's governing board by its members
- Offers any purchased plan contract to all individual members and employer members in this state and includes any members choosing to enroll in the plan contracts offered to the association, provided that the members have agreed to make the required dues payment
- Is an organization covering at least 1,000 persons with the contracted healthcare service plan

For additional information about guaranteed associations, please contact your Blue Shield sales representative.

Declinations

A declination means an eligible employee's refusal to accept coverage under the employer's group health plan because the employee has coverage under another group health plan. The Refusal of Coverage section of the Employee Enrollment Form must be completed if any coverage is declined or refused by an employee and/or his/her eligible family members. Declinations are required for any eligible employee or dependent who opts not to enroll at the time of becoming eligible. This information is required to ensure compliance with federal and state legislation.

Late enrollee

A late enrollee is defined as an eligible employee or dependent who has declined enrollment in a health benefit plan offered by a small employer at the time of the initial enrollment period provided under the terms of the health benefit plan, and who subsequently requests enrollment in a health plan of that small employer, provided that the initial enrollment period shall be a period of at least 60 days.

However, an eligible employee or dependent shall not be considered a late enrollee if:

1. The individual meets one of the following criteria:
    a) He or she was covered under another health benefit plan, the Healthy Families Program, or no share of cost Medi-Cal coverage at the time the individual was eligible to enroll.
    b) He or she certified at the time of the initial enrollment that coverage under another health benefit plan, the Healthy Families Program or no share of cost Medi-Cal coverage, was the reason for declining enrollment, provided that if the individual was covered under another health benefit plan, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollment.
    c) He or she has lost or will lose coverage under another health benefit plan as a result of termination of employment of the individual or person through whom the individual was covered as a dependent; change in employment status of the individual or of a person through whom the individual was covered as a dependent; termination of the other plan's coverage; exhaustion of Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation benefits; cessation of an employer's contribution toward an employee or dependent's coverage; death of the person through whom the individual was covered as a dependent; legal separation or divorce; loss of coverage under the Healthy Families Program, as a result of exceeding the program's income or age limits, or loss of no share of cost Medi-Cal coverage.
    d) He or she requests enrollment within 60 days after the loss of Minimum Essential Coverage, termination of coverage, or cessation of employer contribution toward coverage provided under another health benefit plan.
    e) He or she gains access to new qualified health plan as a result of a permanent move.
    f) His or her enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or the U.S. Department of Health & Human Services or its instrumentalities as evaluated and determined by the Exchange (in such cases, the Exchange may take action, as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction).
    g) He or she adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.

h) He or she is newly eligible or ineligible for advance payments of the premium tax credit or change in eligibility for cost-sharing reductions.

- The enrollee is determined newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions;
- The enrollee's dependent enrolled in the same QHP is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions; **or**
- A qualified individual or his or her dependent who is enrolled in qualifying coverage in an eligible employer-sponsored plan is determined newly eligible for advance payments of the premium tax credit based in part on a finding such that individual will cease to be eligible for qualifying coverage in an eligible employer-sponsored plan in the next 60 days and is allowed to terminate existing coverage. The Exchange must permit an individual whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan, although he or she is not eligible for advance payments of the premium tax credit until the end of his or her coverage through such eligible employer-sponsored plan.

i) He or she is enrolled in an eligible employer-sponsored plan that is not qualifying coverage in an eligible employer-sponsored plan.

j) He or she becomes eligible for premium assistance under Medicaid or the Children's Health Insurance Program (CHIP) or loses eligibility for Medicaid or CHIP.

k) He or she has been released from incarceration.

l) He or she was receiving services from a contracting provider under another health benefit plan for one of the conditions described in subdivision (c) of Section 1373.96 of the Health and Safety Code, and that provider is no longer participating in the health benefit plan.

m) He or she demonstrates to the Exchange, with respect to benefit plans offered through the Exchange, or to the Department of Managed Health Care, with respect to health benefit plans offered outside the Exchange, that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period available to the individual because he or she was misinformed that he or she was covered under minimum essential coverage.

n) He or she is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active-duty service.

2. The employer offers multiple health plans, and the employee elects a different plan during an open enrollment period.

3. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan. The health plan shall enroll a dependent child within 60 days of presentation of a court order by the district attorney, or upon presentation of a court order or requested by a custodial party, as described in subdivision (j) of Section 14124.93 of the California Welfare and Institution Code or Medi-Cal program.

4. For individuals who failed to elect coverage during his or her initial enrollment period and the plan cannot produce a written statement from the employer stating that prior to declining

coverage, the employee or dependent, or the individual through whom he or she was eligible to be covered as a dependent, was provided with a signed acknowledgement of a Refusal of Coverage form specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of his or her late decision to elect coverage, an exclusion from coverage for a period of 12 months, unless he or she meets the criteria specified in paragraphs (1), (2), or (3) above.

5. For eligible employees or dependents who were eligible for coverage under the Healthy Families Program or Medi-Cal and whose coverage is terminated as a result of the loss of such eligibility, provided that enrollment is requested within 60 days after notification of this loss of coverage.
6. For eligible employees or dependents who have lost their coverage under the Healthy Families Program as a result of exceeding the program's income or age limits, and who request enrollment within 31 days after notification of this loss of coverage.
7. For eligible employees who decline coverage during the initial enrollment period and subsequently acquire dependents through marriage, birth, or placement for adoption, and who enroll for coverage for themselves and their dependents within 60 days from the date of marriage, birth, or placement for adoption.

Additionally, late enrollees do not include the following employees:

- **New hires** – Eligible employees in groups who are hired after the group's effective date
- **Re-enrollees** – Eligible employees and eligible dependents of any employer group with one to 100 employees, who choose to discontinue health coverage and later wish to re-enroll
- **Replacement group/members** – All eligible employees/dependents of an employer group who were covered as a group by a prior carrier

Section VIII: State and Federal Regulations

Federal regulations

- The Federal Tax Equity and Fiscal Responsibility Act (TEFRA), Deficit Reduction Act, (DEFRA), and Consolidated Omnibus Budget Reconciliation Act (COBRA) were enacted to regulate employee healthcare coverage. Based on this legislation and the limitations of the Blue Shield agreement, if a business employs an average of fewer than 20 employees in a year, and any employee reaches age 65, the employee's primary carrier must be Medicare. For those employees that are age 65 and choose to retain their Blue Shield small group coverage, Blue Shield will apply contract benefits as a secondary carrier for Medicare benefits paid or payable. This applies whether or not the employee has applied for and has been made effective for Medicare Part A and B coverage. When a member is covered by both Medicare and a Blue Shield contract containing the non-duplication of Medicare clause and Medicare is the primary payer, total benefits provided by Medicare and Blue Shield should equal but not exceed the benefits of group members who do not have Medicare coverage. **This is not a Medicare Supplement plan**. If an employer has fewer than 20 employees, the employees who reach age 65 are eligible for Medicare coverage as if they were not still employed or still enrolled in a Blue Shield plan.
- In addition to those age 65, the following members qualify for Medicare:
    a) Members eligible following the first 18 months of end-stage renal disease
    b) Members who are eligible for Medicare due to disability
- **COBRA**: The employer is primarily responsible for administration (within the guidelines established by the federal government for compliance by employer groups). Blue Shield will help the employer administer within those guidelines.

Cal-COBRA/COBRA continuation coverage

Cal-COBRA/COBRA continuation coverage with Blue Shield of California/Blue Shield of California Life & Health Insurance Company is only available to groups that have a current contract for employee medical benefits with Blue Shield of California/Blue Shield of California Life & Health Insurance Company.

Cal-COBRA (Cal. Health & Safety Code & 1366.20 et seq.) became effective January 1, 1998. (**It applies to groups of two to 19 eligible employees.**)

- Blue Shield administers Cal-COBRA for employers not subject to COBRA. Every California employer that provides group health coverage and that employed two to 19 eligible employees on at least 50% of its working days during the preceding calendar year, or, if the eligible employer was not in business during any part of the preceding calendar year, employed two to 19 eligible employees on at least 50% of its working days during the preceding calendar quarter, is subject to Cal-COBRA.
- For these employer groups, Blue Shield of California will administer Cal-COBRA. Under Cal-COBRA, employers are required to notify Blue Shield within 31 days when an employee terminates employment or is no longer eligible due to a reduction of work hours. Employees that are terminated for "gross misconduct" are not eligible for Cal-COBRA. To notify Blue Shield, please fill out a Cal-COBRA Employer Notification form (C13140) and forward it to the address below. After receipt of the notification, Blue Shield will forward information regarding benefits, rates, and a Cal-COBRA Election form (C13141) to the employee.

The law resulting from AB 1401, enacted in 2002, extends Cal-COBRA coverage to 36 months and offers COBRA enrollees extended coverage under Cal-COBRA.

According to Cal. Health and Safety Code Section 1366.29 added by AB 1401 (effective September 1, 2003), Cal-COBRA coverage is 36 months regardless of the qualifying event. Cal-COBRA enrollees are automatically enrolled for 36 months. COBRA enrollees who have not exhausted 36 months of coverage under COBRA are eligible to apply for a maximum of 36 months under Cal-COBRA. Cal-COBRA coverage is also available to domestic partners when due to a qualifying event, such as termination of the partnership with the employee; however, the domestic partner does not qualify for federal COBRA. A domestic partner only qualifies for federal COBRA as a dependent of the employee.

This extension under Cal-COBRA is administered by Blue Shield, not the federal COBRA administrator. The employer COBRA plan administrator is required to notify COBRA enrollees of the extension under Cal-COBRA in the 90-day COBRA termination letter. This letter will also instruct the COBRA enrollee to contact Blue Shield within 30 days prior to the COBRA termination date to apply.

Dues for Cal-COBRA enrollees will remain at 110% of the group rates, even for enrollees who are disabled. Dues for COBRA enrollees who elect the Cal-COBRA extension are also 110%. Dues for disabled COBRA enrollees are 150% of applicable group dues. Please note that all COBRA coverage must be exhausted, including the disability extension, before the COBRA enrollee is eligible for the Cal-COBRA extension.

We have established a centralized, dedicated team to administer Cal-COBRA. The Cal-COBRA team is located at this address:

Blue Shield of California
Cal-COBRA
P. O. Box 3008
Lodi, CA 95241-1912
Phone: **(800) 228-9476**
Fax: (916) 350-7480

For Cal-COBRA and the COBRA extension under Cal-COBRA, all administration will be handled by Blue Shield. There will be no waivers or exceptions.

The Blue Shield Cal-COBRA team will provide all administrative and membership duties, including the following:

- Receive notices from the employer or enrollee regarding qualifying event
- Process notices of qualifying events and apply eligibility determinations

- Provide Cal-COBRA packets to eligible applicants (employees and/or dependents) within 14 days of receipt of the notice of a qualifying event
- Collect monthly payments for the duration of the Cal-COBRA coverage
- Provide customer service for billing and eligibility questions
- Process cancellations

Producers are responsible for submitting Cal-COBRA questionnaires, applications, and remittance checks with new business.

NOTE: Cal-COBRA rates are 110% of the group rates.

Federal COBRA coverage

Generally, every employer who provides group health coverage and who employed 20 or more full- and/or part-time employees during 50% of the business days in the previous calendar year is subject to federal COBRA. Employers subject to COBRA may use HealthEquity or another COBRA administrator to provide COBRA administration of our accounts.

Disabled COBRA extension

A member's 18-month COBRA period may be extended to 29 months if the member is determined to be disabled under the Social Security Act within the first 60 days of the initial qualifying event, and if he or she notifies his employer before the end of the 18-month period. Dues for months 19 to 29 shall be 150% of the applicable group dues rate.

Extension of COBRA under California Health and Safety Code 1373.621

Effective January 1, 2005, the extension of COBRA for certain individuals who were age 60 or older and had worked for their employer for more than five years was eliminated by state legislation that repealed Section 1373.621 of the Health & Safety Code. Even though this extension of coverage ended, certain individuals who already qualified for this coverage may continue this coverage for up to five years.
This extension of coverage will end on the earliest of the following dates:

- The date the former employee, spouse, or former spouse reaches age 65
- The date the employer ceases to maintain any group health plan
- The date the former employee, spouse, or former spouse transfers to another health plan
- The date the former employee, spouse, or former spouse becomes entitled to Medicare
- For a spouse or former spouse, five years from the date the spouse's COBRA or Cal-COBRA coverage would end.

Dues for this coverage are 213% of the applicable group dues rate for composite-rated groups; all other rated structures are billed at 102% of the applicable group dues rate. All participants are billed directly by Blue Shield.

HIPAA requirements after COBRA and Cal-COBRA termination

Under the Health Insurance Portability and Accountability Act (HIPAA), upon certain events, group health plans and health insurance issuers are required to provide a special enrollment period. During that period, individuals who previously declined coverage for themselves and their dependents, and who are otherwise eligible, may enroll without waiting until the next open enrollment.

If an employee or dependent chooses to elect COBRA or Cal-COBRA continuation coverage, the employee or dependent can request special enrollment in another group health plan or an individual plan once continuation coverage is exhausted. In order to exhaust COBRA or Cal-COBRA coverage, the individual must receive the maximum period of continuation coverage available without early termination.

If an employee or dependent chooses to terminate COBRA or Cal-COBRA continuation coverage early, or COBRA or Cal-COBRA premiums are not paid, there is generally no entitlement to special enroll in other group health coverage or an individual plan.

Employer option to include part-time employees

Under California Health and Safety Code, a small group employee is required to work an average of 30 hours per week to be eligible for coverage. However, state law also provides the employer an option to offer coverage to part-time employees, as long as the following criteria are met:

- All other eligibility requirements as a small group are met (refer to Section I of this guide, "Health Plan General Requirements").
- The employer offers coverage to all similarly situated employees. For example, if an employer chooses to offer coverage to employees working 23 hours per week, then all employees working a minimum of 23 hours or more per week are to be offered coverage. Enrollment applications and refusals must be submitted for all eligible employees.
- The employer must indicate the intent to offer coverage under this option on the Master Group Application (new groups) or the Group Change Request (existing groups).
- The part-time employees being offered healthcare coverage must have worked a minimum of 50% of the preceding calendar quarter. This is an individual eligibility requirement for each part-time employee being offered coverage under this option.
- If eligibility is not met by the individual employee at the time of group enrollment, the employee must wait until he has worked at least 20 hours, but not more than 29 hours per normal work week for at least 50% of the working days in the previous calendar quarter. Once eligibility is met, enrollment must take place within 30 days of meeting the eligibility requirement. If not, the employee will not be eligible to enroll until the next open enrollment period at renewal.
- This employer option may be added to the group plan at any time during the year. If the option is added off-anniversary, it will be effective on the first of the month following receipt of the request. Part-time employees may not be added to the group plan unless the employer has stated in writing that this feature is available.

If you need more information about eligibility under this option, please contact your Blue Shield of California representative.

Takeover provisions

Blue Shield small group takeover provisions comply with the following:

- Any carrier providing replacement coverage with respect to hospital, medical, or surgical expense or service benefits within a period of 60 days from the date of discontinuance of a prior contract or policy providing such hospital, medical, or surgical expense or service benefits shall immediately cover all employees and dependents who were validly covered under the previous contract or policy providing such hospital, medical, or surgical expense or service benefits at the date of discontinuance, and are within the definitions of eligibility under the succeeding carrier's contract, regardless of any provisions of the contract relating to active full-time employment or hospital confinement or pregnancy.
- However, with respect to employees or dependents who are totally disabled on the date of discontinuance of the prior carrier's contract or policy, and who are entitled to an extension of benefits pursuant to subdivision (b) of Section 1399.62 or pursuant to subdivision (d) of Section 10128.2 of the Insurance Code, the succeeding carrier is not required to provide benefits for services or expenses directly related to any condition which caused the total disability, except to the extent it may apply any applicable pre-existing conditions limitation (giving credit for prior coverage as required by law).

Confidentiality of personal and health information

Blue Shield is committed to maintaining the confidentiality of our members' personal and health information (PHI). This includes both medical and individually identifiable information, such as addresses, Social Security

numbers, health plan identifiers, and telephone numbers, etc. Because we believe that the privacy of members' personal and health information is critical to their receiving quality health care, we strive to ensure that this information remains confidential. We maintain our confidentiality policies throughout all divisions of our organization.

We understand that confidentiality is important to our members, whether they are prospective, current, or former members. We respect their concerns regarding the use and disclosure of personal and health information and want you and them to be informed about our policies regarding the use and disclosure of their PHI.

When a prospective member completes an application for Blue Shield healthcare coverage and becomes a Blue Shield member, his or her signature authorizes us to communicate with that member's physicians and other providers regarding treatment, payment, and healthcare operation decisions.

As part of our commitment to improve our members' healthcare services, Blue Shield participates in quality measurement activities that may require us to access our members' personal and health information. We have policies to protect this information from inappropriate disclosure and only release this information as aggregated or redacted data.

We will not disclose, sell, or otherwise use members' personal and health information unless permitted by law, and only to the extent necessary, to administer the health plan. We will obtain a written authorization from a member to use his or her personal and health information for any other purpose other than treatment, payment, or healthcare operations. We will not release a member's personal and health information without that member's specific authorization unless the law permits such a release. For any of our prospective or current members who are unable to give an authorization, we have a policy in place to protect their rights. This policy permits their legally authorized representatives to authorize the release of their personal and health information.

Through our contracts with physicians and other providers, Blue Shield has policies in place to allow members to inspect their medical records maintained by their physicians or other providers and, when needed, include a written statement from the member. Members also have the right to review personal and health information that may be maintained by Blue Shield.

You and our prospective, current, and former members can get more detailed information about Blue Shield's confidentiality and privacy practices from our website at **blueshieldca.com**. Blue Shield's Corporate Notice of Confidentiality & Privacy Practices may be obtained by calling Member Services at **(800) 424-6521** (for HMO members) or Customer Service at **(800) 200-3242** (for PPO and prospective members). The Notice of Confidentiality and Privacy Practices is automatically sent to all new members upon enrollment.

Meeting your obligations

1. Providing health coverage information

Any producer, solicitor, or solicitor firm providing general information on coverage to a small employer (one to 100 employees) but not specifically recommending particular health plan contracts must:

a) Advise the employer that any carrier must sell to any eligible small employer any health plan contract the carrier offers to small employers, and that the carrier must provide the actual rates for any of those plans upon request.

b) Notify the employer that, upon request, you will provide Blue Shield's *Small Business Medical Sales Guide 1-100 Employees* and rate and benefit information on any small employer health plan contract offered by that carrier.

c) Any producer, solicitor, or solicitor firm that is recommending a particular health plan contract must advise the small employer that, upon request, he or she will provide that plan's benefit summary guide. To obtain Blue Shield's *Small Business Medical Sales Guide 1-100 Employees* guide, A46718, you may either download the

document from the collateral section of our Producer Connection at **blueshieldca.com** or call Producer Services at **(800) 559-5905** for a copy. Full benefit summaries, EOCs, and SBCs for each group may be obtained from Broker Connection.

2. Submitting an application

Before submitting a health plan application for a small group employer, you must:

a) Provide the employer with Blue Shield's *Small Business Medical Sales Guide 1-100 Employees* and the sum of the standard employee risk rates for every Blue Shield plan contract offered to small employers.

3. Certifying your compliance

a) Obtain a signed statement from the small employer acknowledging that the employer has received the disclosures required under "Submitting an Application."

4. Things you must avoid

You cannot, either directly or indirectly:

a) Induce or otherwise encourage a small employer to separate or otherwise exclude an employee from a health plan contract provided in connection with the employee's employment.

b) Encourage or direct small employers to refrain from submitting an application for coverage with a plan because of the small employer's health status, claims experience or industry, or the occupation or geographic location (unless it is outside of the plan's approved service area) of the small employer.

c) Encourage or direct small employers to seek coverage from another plan or the voluntary purchasing pool because of a small employer's health status, claims experience or industry, or the occupation or geographic location (unless it is outside of the plan's approved service area) of the small employer.

d) Enter into any contract, agreement, or arrangement that provides for or results in greater or lesser compensation being paid for the sale of a health plan because of the small employer's health status, claims experience or industry, or the occupation or geographic location of the small employer. This does not apply to compensation on the basis of a percentage of dues.

If you willfully violate the provisions of California Health and Safety Code, you are liable for a penalty of not less than $500 for the first violation and a penalty of not less than $2,000 or more than $5,000 for each subsequent violation. In addition, you will be in breach of your Blue Shield Producer's Agreement and could be held liable for damages under such a breach or terminated because of such a breach.

Section IX: Specialty Benefit Plan Guidelines

General requirements

- The group must employ at least one "common-law employee" who is also an "eligible employee."
  - A common-law employee is defined by the Internal Revenue Service (IRS) as anyone who performs services for an employer if the employer can control what will be done and how it will be done.
  - For purposes of determining whether an employer has one employee, sole proprietors and their spouses or domestic partners, and partners of a partnership and their spouses or domestic partners, and 2% S-Corporation shareholders are not employees.
- The group must qualify as an employer in this state.

Documentation requirements

Refer to the "New group enrollment checklist" on page 15 for submission requirements.

Eligible employees

The following criteria determine if an individual is an "eligible employee" and is eligible for enrollment in the group specialty benefit plans:

- Work on a full-time basis in the conduct of the business of the employer, whose normal work week is an average of 30 hours and whose duties in such employment are performed at the employer's regular places of business (subject to withholding on a W-2 form), **or**
- Be a sole proprietor, corporate officer, or partner of a partnership engaged on a full-time basis, an average of 30 hours per week, in the employer's regular places of business
- Work at least 20 hours, but no more than 29 hours, per week, in the employer's business on a permanent, year-round basis and meet the individual employee criteria for an eligible part-time employee
- Receive monetary compensation (W-2 employee) for that work by the employer
- Be a bona fide employee of the employer (a bona fide employee/employer relationship must exist)
- Have met any applicable employer-imposed eligibility waiting period
- The following individuals are **not** considered "eligible employees" and are not eligible for coverage:
  - Retirees
  - Part-time (unless offered by the employer and meet the requirements of an eligible part-time employee), temporary, substitute or seasonal employees (seasonal or substitute employees, defined as employees hired with a planned future termination date, are not eligible)
  - 1099 independent contractors
  - Domestic help
  - Employees participating in a multiple employer group
  - Leased employees or employees part of a co-employment or PEO relationship (see "Professional Employer Organization ("leased") employees" in Section IV)
  - Employees living outside of the United States

Employer option to include part-time employees

The employer has the option to offer coverage to part-time employees, as long as the following criteria are met:

- **The employer offers coverage to all similarly situated employees.** For example, if an employer chooses to offer coverage to employees working 23 hours per week, then all employees working a minimum of 23 hours or more per week are to be offered coverage.
- **The employer must indicate the intent to offer coverage under this option on the Master Group Application,** as well as state the minimum weekly hours chosen (no fewer than 20).

- The part-time employees being offered coverage must have worked a minimum of 50% of the preceding calendar quarter. This is an individual eligibility requirement for each part-time employee being offered coverage under this option.
- Once eligibility is met, enrollment must take place within 30 days of meeting the eligibility requirement. If not, the employee will not be eligible to enroll until the next open enrollment period at renewal.
- This employer option may be added to the group plan at any time of the year. If the option is added off-anniversary, it will be effective the first of the month following receipt of the request. Part-time employees may not be added to the group plan unless the employer has stated in writing that this feature is available.

If you need more information about eligibility under this option, please contact your Blue Shield of California representative.

Employer waiting period

A group may impose an eligibility waiting period for employees.

- The waiting period may be waived for all employees for the initial group enrollment.
- Blue Shield will administer the same waiting period for all employees or a maximum of two differing waiting periods based on employee classification.
- The waiting period for every employee classification must comply with applicable federal and California state law, and any rules and regulations implementing those requirements.
- The employer must notify Blue Shield of the waiting periods it has in place, which are consistent with the following four options:
    - Effective the first day of the month following the date of hire
    - Effective the first day of the month following 30 days from the date of hire
    - Effective the first day of the month following 60 days from the date of hire
    - Effective on the 91st day following the date of hire. When the 91st day effective date results in a partial month of coverage, that partial month of coverage will be reflected on the employer's next monthly bill.

Small business dental plans – general requirements

Dental plans may be written with or without a Blue Shield medical plan.

Small business dental plans are available to groups with one to 100 employees.

Employer dues/premium contribution requirements

- The employer must contribute at least 50% of the total employee rate.
- The employer may contribute any amount from 0% to 100% for voluntary plans.
- When a voluntary dental plan is combined with a contributory dental plan under the provisions of dual or triple option guidelines, a total combined contribution of 50% is required.
- The employer may contribute the same amount for all employees or a maximum of two differing amounts based on employee classification. Contributions must meet the minimum requirement (above) and comply with the group contract.
- The employer must agree to make the required premium payments.
- There is no minimum contribution requirement for dependents.
- Payroll deduction is required if contributory.

New group eligibility/effective date

- The eligibility date for existing employees and dependents is the group's effective date, unless new hires have not yet satisfied their group-imposed waiting period.
- Once rates are quoted to the employer group, the employer then has 30 days in which to accept coverage at the quoted rates. Once accepted, the employer can

opt to change Blue Shield plan contracts to a different plan of benefits during the first 30 days after the group's effective date.

- However, once quoted rates are accepted by a group, the group cannot cancel coverage without being considered a canceled or terminated group.
- The employer has the option, at initial group enrollment only, to waive the waiting period for all new hires.
- Groups will not be guaranteed an effective date unless complete and correct group enrollment materials are received and approved by Blue Shield.

DHMO service area

- To offer DHMO plans, the employer's place of business must be located in Blue Shield's DHMO plan service area.
- Dental HMO plans are not designed to provide coverage for employees who reside outside California.
- With a DHMO plan, eligible employees and family members must live or work in an area served by the Blue Shield DHMO plan.
- Employers with employees who reside or work more than six months outside California should consider a DPPO plan.
- The Blue Shield DHMO service area is identified in the *DHMO Physician Directory.*
- Each enrolled employee and dependent must have a designated primary care dentist. Each member may select a different primary care dentist, as long as each provider is located adequately close to the member's home or work address to ensure access to care, as determined by Blue Shield.

Small business dental plan participation requirements

The group must maintain the required minimum participation requirements set forth below to remain eligible (or 100% participation, if non-contributory). Groups are subject to non-renewal if participation falls below the required minimum.

- Contributory plans require a minimum of one employee and at least 65% of all eligible employees must enroll in the Blue Shield plan(s).
- Voluntary dental plans require a minimum of one enrolling eligible employee.
- An employee may enroll in only one dental plan.
- Blue Shield dental plans may not be offered alongside another carrier's dental plans.
- Any two dental plan options may be selected under the dual option provision.
  - Combined participation between the two offered dental plans must meet minimum requirements. Enrollment in both options is not required for a dual plan offering; however, as noted above, voluntary dental plans require a minimum of one enrolling eligible employee.
- The following combination of three dental plans may be selected:
  - Any two DHMO plans with any one DPPO plan
  - Any three DHMO plans
- The following **additional** combination of three dental plans may be selected only when purchased with Blue Shield of California small business medical coverage:
  - Two DPPO plans that have an orthodontic benefit or two DPPO plans that do not have an orthodontic benefit with any one DHMO plan
- 100% contribution/participation requirements:
  - If the group contributes 100% of dues/premium, then 100% of eligible employees must enroll (except those waiving due to other group coverage through another employer).
- Declining or waiving coverage:
  - A Refusal of Coverage form (C19927) is required if refusing coverage with Blue Shield. When coverage is refused due to coverage with another carrier through a different employer, it is not counted toward the participation requirement.

- If an eligible employee and spouse or domestic partner both work for the same employer, they may enroll separately as employees or one may enroll as a dependent on the other's coverage. They cannot enroll in a plan as both subscriber and dependent, and when the group offers more than one product such as medical and dental, they cannot enroll as subscriber in one product and as dependent in another.

  Any child(ren) of such persons may be enrolled as the dependent(s) of either employee, but not both.
- If children of an employee work for the same employer, they may enroll separately as employees, or if eligible they may enroll as dependents on the parent-employee's coverage. They cannot enroll in a plan as both subscriber and dependent, and when the group offers more than one product such as medical and dental, they cannot enroll as subscriber in one product and as a dependent in another.

Small business dental plan notes

- Employers whose place of business is located outside of Blue Shield of California's DHMO service areas will not have the option of offering a DHMO plan. An enrolling employee and any dependents must live or work in the service area of the DHMO plan they are enrolling in.
- Dental plan requirements are the same regardless of whether paired with a medical Off-Exchange Package for Small Business or a medical Mirror Package for Small Business.

Rating policies

- All rates will be based on the total number of eligible employees.
- Rates are based on a four-tier rating structure at the employee level.
- Rates are based on the employer's principal business address.
- Final rates, effective date, and acceptability of the group will be determined by Blue Shield.
- Approved out-of-state employees will be charged an area rate based on the location of the employer's principal business address in California.

Rate changes

The group's rate will not change more often than every 24 months for new groups or every 12 months for renewing groups.

Coverage guarantee

New groups have a 24-month coverage guarantee, and renewing groups have a 12-month coverage guarantee. During these 24 or 12 months, respectively, Blue Shield will cancel coverage only for the following reasons:

- The employer does not pay the required premium.
- The employer does not contribute toward employee premium, unless a voluntary dental plan is offered.
- The employer commits any act of fraud or misrepresentation.
- The group's eligibility drops below the required minimum, in which case the group will be canceled at its anniversary date.
- The employer moves outside of the Blue Shield of California–approved service area.
- The group does not continue to meet participation and contribution requirements.

Coverage of any employee or dependent may be rescinded or canceled if an individual or his or her representative commits any act of fraud or misrepresentation.

Small business vision plans[1] – general requirements

Small business vision plans may be written with or without a Blue Shield medical plan.

Small business vision plans are available to groups with one to 100 employees.

[1] Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

Employer dues/premium contribution requirements

- The employer must contribute a minimum of 25% of the total employee rate.
- The employer may contribute any amount from 0% to 100% for voluntary plans.
- When a voluntary vision plan is combined with a contributory vision plan under the provisions of the dual option guidelines, a total combined contribution of 25% is required.
- The employer may contribute the same amount for all employees or a maximum of two differing amounts based on employee classifications. Contributions must meet the minimum requirement (above) and comply with the group contract.
- The employer must agree to make the required premium payments.
- There is no minimum contribution requirement for dependents.
- Payroll deduction is required if contributory.

New group eligibility/effective date

- The eligibility date for existing employees and dependents is the group's effective date, unless new hires have not yet satisfied their group-imposed waiting period.
- Once rates are quoted to the employer group, the employer then has 30 days in which to accept coverage at the quoted rates. Once accepted, the employer can opt to change Blue Shield plan contracts to a different plan of benefits during the first 30 days after the group's effective date.
- However, once quoted rates are accepted by a group, the group cannot cancel coverage without being considered a canceled or terminated group.
- The employer has the option, at initial group enrollment only, to waive the waiting period for all new hires.
- Groups will not be guaranteed an effective date unless complete and correct group enrollment materials are received and approved by Blue Shield.

Small business vision plan participation requirements

The group must maintain the required minimum participation requirements set forth below to remain eligible (or 100% participation, if non-contributory). Groups are subject to non-renewal if participation falls below the required minimum.

- Contributory plans require a minimum of one employee, and at least 65% of all eligible employees must enroll in the Blue Shield plan(s).
- Voluntary vision plans require a minimum of one eligible enrolling employee.
- An employee may enroll in only one vision plan.
- Blue Shield vision plans may not be offered alongside another carrier's vision plans.
- Any two vision plans may be selected under the dual option provision.
    - Combined participation between the two offered vision plans must meet minimum requirements. Enrollment in both options is not required for a dual plan offering; however, as noted above, voluntary vision plans require a minimum of one enrolling eligible employee.
- 100% contribution/participation requirements:
    - If the group contributes 100% of dues/premium, then 100% of eligible employees must enroll (except those waiving due to group coverage through another employer).
- Declining or waiving coverage:
    - A Refusal of Coverage form (C19927) is required if refusing coverage with Blue Shield. When coverage is refused due to coverage with another carrier through a different employer, it is not counted toward the participation requirement.
    - If an eligible employee and spouse or domestic partner both work for the

same employer, they may enroll separately as employees or one may enroll as a dependent on the other's coverage. They cannot enroll in a plan as both subscriber and dependent, and when the group offers more than one product such as medical and dental, they cannot enroll as subscriber in one product and as dependent in another.

Any child(ren) of such persons may be enrolled as the dependent(s) of either employee, but not both.

- If children of an employee work for the same employer, they may enroll separately as employees, or if eligible they may enroll as dependents on the parent-employee's coverage. They cannot enroll in a plan as both subscriber and dependent, and when the group offers more than one product such as medical and dental, they cannot enroll as subscriber in one product and as a dependent in another.

Small business vision plan notes

Vision plan requirements are the same regardless of whether paired with a medical Off-Exchange Package for Small Business or a medical Mirror Package for Small Business.

Rating policies

- All rates will be based on the total number of eligible employees.
- All rates will be based on the employer's principal business address.
- Rates are based on a four-tier rating structure at the employee level.
- Final rates, effective date, and acceptability of the group will be determined by Blue Shield.

Rate changes

The group's rate will not change more often than every 24 months for new groups or every 12 months for renewing groups.

Coverage guarantee

New groups have a 24-month coverage guarantee, and renewing groups have a 12-month coverage guarantee. During these 24 or 12 months, respectively, Blue Shield will cancel coverage only for the following reasons:

- The employer does not pay the required premium.
- The employer does not contribute toward employee premium, unless a voluntary vision plan is offered.
- The small employer commits any act of fraud or misrepresentation.
- The group's eligibility drops below the required minimum, in which case the group will be canceled at its anniversary date.
- The employer moves outside of the Blue Shield of California-approved service area.
- The group does not continue to meet participation and contribution requirements.

Coverage of any employee or dependent may be rescinded or canceled if an individual or his or her representative commits any act of fraud or misrepresentation.

Small business life insurance[2] – general requirements

Life insurance plans may be written with or without a Blue Shield medical plan.

Small business life insurance plans are available to groups with two to 100 employees.

SIC limitations

The following SIC codes present special risks for groups of two to nine eligible employees not written with a Blue Shield medical product and are not eligible for a basic life insurance policy:

0721, 0912, 0913, 0919, 0921, 0971, 1011, 1021, 1031, 1041, 1044, 1061, 1081, 1094, 1099, 1221, 1222, 1231, 1241, 1311, 1321, 1381, 1382, 1389, 1411, 1422, 1423, 1429, 1442, 1446, 1455, 1459, 1474,

[2] Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

1475, 1479, 1481, 1499, 1761, 1795, 2411, 2812, 2813, 2816, 2819, 2821, 2824, 2851, 2861, 2865, 2869, 2873, 2874, 2875, 2879, 2891, 2892, 2893, 2895, 2899, 2911, 2951, 2952, 2992, 2999, 3292, 4119, 4121, 4412, 4424, 4432, 4449, 4481, 4482, 4489, 4491, 4492, 4493, 4499, 4512, 4513, 4522, 4581, 5813, 6732, 6733, 7911, 7922, 7929, 7933, 7941, 7948, 7991, 7992, 7993, 7996, 7997, 7999, 8611, 8621, 8631, 8641, 8651, 8661, 8699, 8811, 9111, 9131, 9199, 9211, 9221, 9222, 9224, 9229, 9711, 9721, 9999

Employer dues/premium contribution requirements

- The employer must contribute a minimum of 25% of the total employee rate.
- The employer must agree to make the required premiums payments.
- The employer may contribute the same amount for all employees or a maximum of two differing amounts based on employee classifications. Contributions must meet the minimum requirement (above) and comply with the group contract.
- There is no minimum contribution requirement for dependent life insurance plans.
- Payroll deduction is required if contributory.

New group eligibility/effective date

- The eligibility date for existing employees and dependents is the group's effective date, unless new hires have not yet satisfied their group-imposed waiting period.
- Once rates are quoted to the employer group, the employer then has 30 days in which to accept coverage at the quoted rates. Once accepted, the employer can opt to change Blue Shield plan contracts to a different plan of benefits during the first 30 days after the group's effective date.
- However, once quoted rates are accepted by a group, the group cannot cancel coverage without being considered a canceled or terminated group.
- The employer has the option, at initial group enrollment only, to waive the waiting period for all new hires.
- Groups will not be guaranteed an effective date unless complete and correct group enrollment materials are received and approved by Blue Shield.

Additional enrollment and plan criteria

Special enrollment period for groups of 2–50 employees purchasing life insurance

New group applications received between November 15 and December 15 requesting a January 1 effective date are eligible for coverage without meeting the minimum participation and contribution requirements.

- The group must meet all other eligibility requirements.
- The group must meet the minimum participation requirements upon renewal to continue coverage.
- Groups with 51–100 employees do not qualify for Blue Shield's life insurance special enrollment period.

Small business life insurance participation requirements

The group must maintain the required minimum participation requirements set forth below to remain eligible (or 100% participation, if non-contributory). Groups are subject to non-renewal if participation falls below the required minimum.

- Contributory plans require a minimum of two employees, and at least 65% of all eligible employees must enroll in the Blue Shield plan(s).
- Blue Shield life insurance plans may not be offered alongside another carrier's life insurance plans.
- 100% contribution/participation requirements:
  - If the group contributes 100% of dues/premium, then 100% of eligible employees must enroll.
- Declining or waiving coverage:
  - A Refusal of Coverage form (C19927) is required if refusing coverage with Blue

Shield. When coverage is refused due to coverage with another carrier through a different employer, it is not counted toward the participation requirement.

- If an eligible employee and spouse or domestic partner both work for the same employer, they may enroll separately as employees or one may enroll as a dependent on the other's coverage. They cannot enroll in a plan as both subscriber and dependent, and when the group offers more than one product such as medical and dental, they cannot enroll as subscriber in one product and as dependent in another.

  Any child(ren) of such persons may be enrolled as the dependent(s) of either employee, but not both.
- If children of an employee work for the same employer, they may enroll separately as employees, or if eligible they may enroll as dependents on the parent-employee's coverage. They cannot enroll in a plan as both subscriber and dependent, and when the group offers more than one product such as medical and dental, they cannot enroll as subscriber in one product and as a dependent in another.

Small business life insurance notes

- Life insurance requirements are the same regardless of whether paired with a medical Off-Exchange Package for Small Business or a medical Mirror Package for Small Business.

- Plan designs available include:
  - Flat amount:
    - $15,000 to $200,000 available in increments of $5,000. See plan guidelines/schedule of guarantee issue amounts available below.

    All employees are covered at the same flat amount.
  - Graded schedule:
    - Employees are divided up to a maximum of four classes that have different levels of benefits.
    - Classes can be either flat or multiple of salary, and this selection can vary for each class.
    - The flat benefit amount or maximum benefit amount (multiple of salary plans) for each class must be no more than 2.5 times the flat benefit amount or maximum benefit amount of the next lower class.
    - See plan guidelines/schedule of guarantee issue amounts available below.
  - Plan guidelines/schedule of guarantee issue amounts available in increments of $5,000 for flat amount and graded schedule:
    - 2-9 eligible employees: $15,000 - $50,000
    - 10-24 eligible employees: $15,000 - $100,000
    - 25-50 eligible employees: $15,000 - $150,000
    - 51-100 eligible employees: $15,000 - $150,000 **or** $175,000 **or** $200,000
  - Multiple of salary:
    - All employees are covered for the same multiple of salary at either one or two times the annual earnings up to the maximum guarantee issue amount. If offered in a graded schedule, one or more employee classes may be covered at one times annual earnings and other employee classes may be covered at two times annual earnings, up to the maximum guarantee issue amount.
    - Only portfolio multiple of salary life insurance plans (based on the number of eligible employees) may be offered.
    - Benefit amounts established by salary are rounded to the next highest $1,000.

- **1x multiple of salary** plan guidelines/ schedule of guarantee issue amounts:
  - 2-9 eligible employees:
    $15,000 minimum/$30,000 maximum **or**
    $15,000 minimum/$50,000 maximum
  - 10-100 eligible employees:
    $15,000 minimum/$50,000 maximum

    $15,000 minimum/$75,000 maximum

    $15,000 minimum/$100,000 maximum

    $15,000 minimum/$125,000 maximum

    $15,000 minimum/$150,000 maximum

    $15,000 minimum/$175,000 maximum

    $15,000 minimum/$200,000 maximum

    $15,000 minimum/$250,000 maximum

    $15,000 minimum/$300,000 maximum
- **2x multiple of salary** plan guidelines/ schedule of guarantee issue amounts:
  - 2-9 eligible employees:
    $15,000 minimum, $30,000 maximum **or**
    $15,000 minimum, $50,000 maximum
  - 10-50 eligible employees:
    $15,000 minimum/$50,000 maximum

    $15,000 minimum/$75,000 maximum

    $15,000 minimum/$100,000 maximum

    $15,000 minimum/$125,000 maximum

    $15,000 minimum/$150,000 maximum

    $15,000 minimum/$175,000 maximum

    $15,000 minimum/$200,000 maximum

    $15,000 minimum/$250,000 maximum

    $15,000 minimum/$300,000 maximum

    $15,000 minimum/$350,000 maximum

    $15,000 minimum/$400,000 maximum
    $15,000 minimum/$450,000 maximum

    $15,000 minimum/$500,000 maximum
  - 51-100 eligible employees:
    $15,000 minimum/$50,000 maximum

    $15,000 minimum/$75,000 maximum

    $15,000 minimum/$100,000 maximum

    $15,000 minimum/$125,000 maximum

    $15,000 minimum/$150,000 maximum

    $15,000 minimum/$175,000 maximum

    $15,000 minimum/$200,000 maximum

    $15,000 minimum/$250,000 maximum

    $15,000 minimum/$300,000 maximum

    $15,000 minimum/$350,000 maximum

    $15,000 minimum/$400,000 maximum

    $15,000 minimum/$450,000 maximum

    $15,000 minimum/$500,000 maximum

    $15,000 minimum/$550,000 maximum

    $15,000 minimum/$600,000 maximum

- **Dependent life insurance:**
  - The employee must purchase basic life insurance in order for dependent life insurance to be available.

- Coverage amounts available:
  - 2-9 eligible employees:
    - $1,000 to $5,000 per dependent in $1,000 increments
  - 10-100 eligible employees:
    - $1,000 to $5,000 per dependent in $1,000 increments **or**
    - $7,000 per dependent **or**
    - $10,000 per dependent **or**
    - $20,000 per dependent
- Coverage amounts for spouse/domestic partner and/or children will be equal and cannot exceed 50% of the employee's benefit.
- One rate covers all dependents.
- An employee that enrolls in life insurance as an employee cannot be simultaneously covered as a dependent under the same group life insurance plan.
- Basic life insurance benefit amount is reduced to 65% of the original amount at age 65.
- Basic life insurance benefit amount is reduced to 50% of the original amount at age 70.

Rating policies

- All rates will be based on the total number of eligible employees.
- Rates for 2-9 employees are based on an age-banded structure. See Blue Shield's current small business rate manual for details.
- Rates for 10-100 employees are based on a composite rating structure.
  - Blue Shield reserves the right to adjust composite rates based on actual group characteristics and final enrollment.
- Final rates, effective date, and acceptability of the group will be determined by Blue Shield.

Rate changes

The group's rate will not change more often than every 24 months for new groups or every 12 months for renewing groups.

Coverage guarantee

New groups have a 24-month coverage guarantee, and renewing groups have a 12-month coverage guarantee. During these 24 or 12 months, respectively, Blue Shield will cancel coverage only for the following reasons:

- The employer does not pay the required premium.
- The employer does not contribute toward employee premium.
- The small employer commits any act of fraud or misrepresentation.
- The group's eligibility drops below the required minimum, in which case the group will be canceled at its anniversary date.
- The employer moves outside of the Blue Shield of California–approved service area.
- The group does not continue to meet participation and contribution requirements, in which case the group may be canceled at its anniversary date.

Coverage of any employee or dependent may be rescinded or canceled if an individual or his or her representative commits any act of fraud or misrepresentation.

Appendix

Form names and form numbers

Small Business Master Group Application (C15385)

Small Business Employee Enrollment Form (C12914)

Small Business Subscriber Change Request (C675-1)

Refusal of Coverage (C19927)

Small Business Group Change Request (A52260)

Small Group Initial Payment Form (A44591)

Start-up/Spin-off Companies Small Business Eligibility Statement (A49675-START-UP)

Small Business Owner Eligibility Statement (A49675-OWNER)

Continuation of Coverage Application (COBRA and Cal-COBRA) (C52299)

Employee Cancellation Notification (A36965)

Group Cancellation (A55007)