Membership claims and administration for groups with 51+ eligible employees
Welcome to Blue Shield

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

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

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

If you or your employees have questions, the chart below can help you quickly find answers.

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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Whom to contact</strong></td>
<td><strong>For help with</strong></td>
</tr>
<tr>
<td>Large Group Client Services Medical &amp; Dental</td>
<td>Questions about group health plan eligibility, escalated issues, and complex claims questions</td>
</tr>
<tr>
<td>Group billing representative</td>
<td>Billing issues or changes to your health plan account, including routine enrollments, changes, or cancellations</td>
</tr>
<tr>
<td>Cal-COBRA administration</td>
<td>Cal-COBRA eligibility, coverage, extensions, and cancellations</td>
</tr>
<tr>
<td>Employer-administered flexible spending account (FSA)</td>
<td>Questions about FSA programs</td>
</tr>
<tr>
<td>Life/AD&amp;D</td>
<td>Questions about claims, declined services, or minor beneficiaries</td>
</tr>
<tr>
<td>Vision</td>
<td>Vision administrator</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contacts for employees</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Whom to contact</strong></td>
<td><strong>For help with</strong></td>
</tr>
<tr>
<td>Blue Shield of California Member Services</td>
<td>Member assistance for Blue Shield health benefits and services. For language assistance, members can call the number on the back of their Blue Shield ID card.</td>
</tr>
<tr>
<td>Blue Shield of California HMO and POS Member Services</td>
<td>Member assistance for Blue Shield HMO or POS health benefits and services</td>
</tr>
<tr>
<td>Blue Shield of California and Blue Shield of California Life &amp; Health Insurance Company – Member Services</td>
<td>Member assistance for Blue Shield health benefits and services</td>
</tr>
<tr>
<td>Contacts for employees (continued)</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Customer Service Life/AD&amp;D</strong></td>
<td>Member assistance for Blue Shield specialty benefits and services</td>
</tr>
<tr>
<td><strong>Hearing-impaired services</strong></td>
<td>Member service information</td>
</tr>
<tr>
<td><strong>Blue Shield’s mental health service administrator (MHSA)</strong></td>
<td>Claims process and benefit information for substance abuse treatments and mental health benefits; and to get information about filing a claim</td>
</tr>
<tr>
<td><strong>Pharmacy services – prior authorization requests and claims processing issues</strong></td>
<td>Questions and information on drugs requiring prior authorization for medical necessity. Members should have their physician call this number to get prior authorization. Pharmacy representatives can assist pharmacies with processing of claims.</td>
</tr>
<tr>
<td><strong>Mail service pharmacy</strong></td>
<td>To order up to a 90-day supply of a covered maintenance drug for a chronic condition</td>
</tr>
<tr>
<td><strong>Dental HMO Member Services</strong></td>
<td>Member assistance for Blue Shield HMO dental benefits and services</td>
</tr>
<tr>
<td><strong>Dental PPO Member Services</strong></td>
<td>Member assistance for Blue Shield PPO dental benefits and services</td>
</tr>
<tr>
<td><strong>Vision Claims and Benefit Inquiry</strong></td>
<td>Blue Shield vision benefits and claims inquiries</td>
</tr>
<tr>
<td><strong>Vision Member Services</strong></td>
<td>Member assistance for Blue Shield vision plan eligibility, billing, and account management</td>
</tr>
<tr>
<td><strong>Discount Vision Program</strong></td>
<td>Members have access to discounted eye exams, eyewear, and LASIK surgery with participating providers</td>
</tr>
<tr>
<td><strong>Find a Provider – Customer Service</strong></td>
<td>To find a primary care provider or specialist</td>
</tr>
<tr>
<td><strong>American Specialty Health Plans (ASH Plans) for HMO members</strong></td>
<td>Questions about chiropractic and acupuncture benefits and services</td>
</tr>
<tr>
<td><strong>American Specialty Discount Program (ASH Plans)</strong></td>
<td>Questions about discounts on chiropractic, acupuncture, and massage services and to find a provider</td>
</tr>
</tbody>
</table>
Blueshieldca.com

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

**Employer Connection**
Finding information is simple. Just go to blueshieldca.com/employer and select Register Now to get started.

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

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

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

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

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

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

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

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

When they log in, they can:
- See highlights and details of their medical coverage and information about their dental and vision plans
- Access copayment and deductible amounts
- Check the status of claims for the whole family
- Setup Claims Alerts and Paperless delivery of Eligibility of Benefits (EOB) statements
- Order replacement ID cards
- Print temporary ID cards
- Download forms
Find a Provider

- Search for a doctor, Independent Practice Association (IPA) or medical group, hospital, dentist, pharmacy, vision care, or alternative care practitioner
- Print a personalized provider directory
- Compare hospitals and IPA/medical groups, and individual PPO physicians according to quality indicators

make sure you're covered

please log in | or select a plan
Log in to auto-select your plan
Select plans carefully. Different plans feature different providers. Choosing a provider that does not participate in your plan’s network could result in higher costs or denied claims.

provider types
- Doctors
- Facilities
- Dentists
- Vision Care
- Pharmacies

located near
- Enter your City, County, State or Zip

outside the US?

find now

12 doctors

Intner, Fredrica J MFT
Marriage Family Therapist
101 Lombard St 365w
San Francisco, CA 94111
(415) 792-5811
Distance: 2.29 miles
Accepting new Patients

Ailoni-Charas, Orrin MD
Anesthesiology
65 Francisco St S100
San Francisco, CA 94113
(415) 834-3800
Distance: 2.29 miles
Accepting new Patients

Alleman, David G MD

Distance | Alphabetically

Results update with map view

Edit Location

Saving this search
Get results as PDF

Managing your group coverage
Health & Wellness

- Take a Wellness Assessment and participate in a personalized wellness plan with Healthy Lifestyle Rewards
- Learn about and apply for health management programs
- Use Blue Shield’s health encyclopedia to research a condition or treatment
- Review the wide range of wellness discount programs
Pharmacy

• Search for a list of formulary drugs and find generic alternatives
• Check for drug interactions and find information about their medications
• Refill maintenance prescriptions through the mail
• Find a network pharmacy
• Ask a pharmacist a question

Pharmacy

- drug database & formulary: Find information about drugs, coverage or formulary status, costs and generic alternatives.
- drug interactions: Check for interactions among your prescription drugs, over-the-counter medications, dietary supplements and herbal products.
- ask the pharmacist: Submit your question to pharmacists at the University of California, San Francisco, and receive a confidential answer online within two days. Browse the top questions and search an archive of answers.
- find a pharmacy: Locate Blue Shield participating pharmacies where your provider can call in your prescription, prescribe electronically or you can take your written prescription to your local network pharmacy.
  - Find a network specialty pharmacy
  - Find Medicare Part D Prescription Drug Benefit participating pharmacies
- mail-service pharmacy: Use Blue Shield's mail service pharmacy to fill maintenance medications with stabilized dosages for the treatment of long-term conditions such as high blood pressure. The mail service benefit can be used for up to a 60 to 90 day's supply depending on your benefit.
- frequently asked questions: Get answers to questions about pharmacy services provided by Blue Shield.
Health and wellness resources

These programs can help members take control of their health care and get the most value from their healthcare coverage. The programs require no administration on your part, and are available at no extra cost to either you or your employees. Please encourage your employees to use these valuable resources.

<table>
<thead>
<tr>
<th>Resource</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>NurseHelp 24/7™</td>
<td>Call (877) 304-0504, 24 hours a day, seven days a week. Hearing-impaired members can call the TTY line at (800) 855-2881. Or, log in to blueshieldca.com and click on Health &amp; Wellness.</td>
</tr>
<tr>
<td>Registered nurses can give members immediate answers and reliable information about:</td>
<td></td>
</tr>
<tr>
<td>• Minor illnesses and injuries</td>
<td></td>
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<tr>
<td>• Chronic conditions</td>
<td></td>
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<tr>
<td>• Medical tests and medications</td>
<td></td>
</tr>
<tr>
<td>• Preventive care</td>
<td></td>
</tr>
<tr>
<td>LifeReferrals 24/7™</td>
<td>Call (800) 985-2405, 24 hours a day, seven days a week. Hearing-impaired members can call the TTY line at (800) 855-2881. Or, log in to blueshieldca.com and click on Health &amp; Wellness.</td>
</tr>
<tr>
<td>Members can speak confidentially with a team of experienced professionals on a wide variety of topics.*</td>
<td></td>
</tr>
<tr>
<td>• For personal issues like relationship problems and grief</td>
<td></td>
</tr>
<tr>
<td>• For legal and financial questions</td>
<td></td>
</tr>
<tr>
<td>• For child and elder care issues or referrals</td>
<td></td>
</tr>
<tr>
<td>Healthy Lifestyle Rewards</td>
<td>Members can visit blueshieldca.com/hlr to participate. Go to blueshieldca.com/hlrtoolkit to download wellness and Healthy Lifestyle Rewards promotional materials. Go to blueshieldca.com and click on Health &amp; Wellness, then Tools.</td>
</tr>
<tr>
<td>This interactive online program gives members the resources, motivation, and support they need to start and stay on the road to better health. Members will find tools to help with goals of getting in shape, eating right, reducing stress, managing moods, or quitting smoking. Members can take a Wellness Assessment and learn their wellness score.</td>
<td></td>
</tr>
<tr>
<td>Decision support tools</td>
<td>Go to blueshieldca.com, click on Health &amp; Wellness, then Condition Management. Or, call (866) 954-4567 for health management programs or (877) 371-1511 for Prenatal Education.</td>
</tr>
<tr>
<td>Access online tools to help you compare hospitals, explore treatment options for your condition, and learn more about prescription drugs.</td>
<td></td>
</tr>
<tr>
<td>Health management programs</td>
<td></td>
</tr>
<tr>
<td>These programs support self-care for members living with chronic conditions such as asthma, diabetes, heart failure, chronic obstructive pulmonary disease, and heart disease. Blue Shield also offers programs that support and educate members about pregnancy, childbirth, and newborns. Members are contacted once identified and they can also enroll online.</td>
<td></td>
</tr>
</tbody>
</table>

* All services are confidential. Some services may not be available to all Blue Shield members; check your group plan Evidence of Coverage to see what it offers. Referrals to community resources are available for no extra cost, but any costs associated with using these resources are the responsibility of the member. NurseHelp 24/7 and LifeReferrals 24/7 are designed to complement, not replace, their care.
Wellness discount programs¹ – Cost-saving options available to members:

Weight Watchers – Members enjoy a wide range of savings, including online subscriptions, at-home kits, and local meeting monthly pass discounts to help them lose those extra pounds and maintain a healthy weight.

24 Hour Fitness – To help them get and stay fit, members receive waived enrollment, initiation and processing fees, and discounted monthly dues (amounts may vary by location).

ClubSport and Renaissance ClubSport – Increase your wellness with saving options on membership dues and fees as well as on-site amenities.

Alternative Care Discount Program – Provides up to 25% discount off the usual and customary fees from participating acupuncture, chiropractic, and massage therapy practitioners and online discounts off the suggested manufacturer’s retail price on a broad selection of quality health and wellness products, with free shipping on most items.

Vision services – Blue Shield vision plan members receive a 20% discount off the published retail prices when they use a participating California provider in the Discount Vision Program network² for these services and supplies: routine eye exams, frames and lenses, including photochromic lenses, tints and coatings, extra pair of glasses, and non-prescription sunglasses.

LASIK – Gives members access to a 15% discount on LASIK and PRK correction surgery through the TLCVision provider network in California.² Members receive a 20% discount through the QualSight network in California.

Members can get more detailed information about discounts at blueshieldca.com/wellnessdiscounts.
1 The networks of practitioners and facilities in the discount programs are managed by the external program administrators identified below, including any screening and credentialing of providers. Blue Shield does not review the services provided by discount program providers for medical necessity or efficacy. Nor does Blue Shield make any recommendations, representations, claims, or guarantees regarding the practitioners, their availability, fees, services, or products. Some services offered through the discount program may already be included as part of the Blue Shield health plan covered benefits. Members should access those covered services prior to using the discount program. Members who are not satisfied with products or services received from the discount program may use the Blue Shield grievance process described in the Grievance Process section of the Evidence of Coverage or Certificate of Insurance. Blue Shield reserves the right to terminate this program at any time without notice.

Discount programs administered by or arranged through independent companies:

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

2 The Discount Vision Program network is currently available in Arizona, California, Colorado, Idaho, Nevada, Utah, Oregon, Texas, and Washington.
Electronic enrollment options

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

**Direct Submission with optional Employer Connection access**
Blue Shield allows employers or their third-party benefits administrator (TPA) to electronically submit enrollment data directly to Blue Shield at no extra charge. Direct submission is typically a good solution for employers who:
- Utilize a human resource information system (HRIS) to manage employee enrollment data; or
- Already utilize the services of a Web-based benefits enrollment vendor

To get started with direct electronic submission, your group simply needs:
- Enrollment data in one of our many acceptable file formats, including ANSI 834
- Electronic file transmission capabilities through SFTP (secure file transfer protocol)
- Ability to submit files early in the enrollment process
- A technical and human resources point of contact for Blue Shield

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


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

**Employer Connection**
As a complement to your direct submission method, Blue Shield offers secure online account-viewing capabilities via Employer Connection at no extra cost, which can be helpful for:
- Viewing Blue Shield’s source system to verify transmissions from your HRIS
- Conducting audits and/or reconciling your bill
- Obtaining employee listing by subscriber number
- Viewing plan benefit details, including eligibility rules and covered services, specific to your plan(s)

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

Once activated, your group’s primary contact can then grant Employer Connection access rights to others within your organization, or even to your broker or TPA.
Eligibility requirements at a glance

Keep this helpful overview of eligibility requirements at your desk – simply print this page.

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

<table>
<thead>
<tr>
<th>Type of enrollee</th>
<th>Requirements</th>
</tr>
</thead>
</table>
| Employee – permanent, year-round, full-time          | • Works at least 30 hours per week  
• Performs job duties at your company’s usual place of business                                         |
| Employee – part-time                                  | • Works 20 to 30 hours per week                                                                                                               |
| Employee – temporary                                  | Not eligible for Blue Shield group coverage unless your Group Health Service Contract or Policy includes a special provision extending coverage to them. |
| Sole owner or partner of a partnership                | • Full-time employee  
• Works at least 30 hours per week  
• Performs job duties at your company’s usual place of business  
• Qualifies as an employee under your company’s Blue Shield Group Health Service Contract |
| Spouse                                               | • Legally married spouse who is not legally separated from the employee                                                                      |
| Domestic partner                                      | • Domestic partner who is not terminated from the domestic partnership  
• Domestic partners are covered under the same terms and conditions as spouses                                                                   |
| Dependent children*                                   | Child of an employee (or employee’s spouse or domestic partner) by birth, legal adoption, placement for adoption, or legal guardianship who is:  
• Under age 26* or older if disabled.                                                                      |
| Disabled over-age dependent children                  | If a disabled child who is covered under a Blue Shield plan reaches the maximum age limit, coverage may continue if the child meets both of the following criteria. The child is:  
• Incapable of self-sustaining employment because of a mentally or physically disabling injury, illness, or condition; and  
• Unmarried and dependent on the member for economic support.                                                                                     |
| Individuals ineligible for group coverage             | If part-time and temporary employees who are not eligible for your group coverage express interest in finding a plan that’s right for them, they can apply directly to Blue Shield for health coverage through an Individual and Family Plan.  
Please contact your Blue Shield sales representative for more information.                                                                                   |

Table 2

* The Patient Protection and Affordable Care Act redefined dependent children as of September 23, 2010 (for employer-sponsored plans, the later of September 23, 2010, or the first plan renewal date thereafter). For more information on reform updates, please visit Producer Connection at blueshieldca.com/producer-health-reform.
Eligibility requirements

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

Employee eligibility

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

Full-time employees

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

- Works at least 30 hours per week (this number may vary depending on your company’s personnel policy)
- Receives wages, commissions, or a salary
- Performs job duties at your company’s usual place of business, unless the job requires traveling

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

Part-time and temporary employees

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

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

Rehired employees

A former employee who is rehired is eligible for coverage on the rehire date if the individual completed your company’s eligibility waiting period during the prior employment period and meets one of the conditions below. He or she:

- Resumed active employment within six months of loss of coverage with your company; or
- Terminated during the prior employment period to enter the Armed Forces, and resumed active employment within the time outlined by the law; or
- Terminated due to a disability, and resumed active work within one month after recovering from the disability.

Otherwise, the rehired individual will be considered a new employee and is required to complete your company’s new-hire eligibility waiting period.

Please note: Reemployment notification must be indicated on the rehired individual’s Employee Application.
Dependent eligibility
This section covers eligibility requirements for five categories of dependents.

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

Note: Same-gender marriages performed in California on or after June 16, 2008, and prior to November 5, 2008, are lawful in California. Same-gender marriages lawful in other states that were performed prior to November 5, 2008, will also be recognized as valid marriages in California. Same-gender marriages lawful in other states that were performed on or after November 5, 2008, will have all the same legal rights and obligations of spouses with the sole exception of the designation of “marriage.” Blue Shield treats same-gender spouses exactly the same as opposite-gender spouses.

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

1. Narrow coverage: Both partners have registered with the state of California by filing a Declaration of Domestic Partnership. Both partners must be of the same sex, with one exception: Opposite-sex partners are allowed if one partner is at least age 62 and eligible for Social Security.

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

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

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

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

- Not a company employee; and
- Younger than age 26, or older if disabled (see following information for disabled over-age dependent children).

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

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

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

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

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

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

Qualified Medical Child Support Order (QMCSO)

A dependent child who is ordered to have coverage by the court cannot be denied because he or she is:

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

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

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

Enrollment paperwork for court-ordered dependent children must be submitted as soon as possible. Include a copy of the employee’s Subscriber Change Request form and a copy of the employee’s court orders. If the employee is not currently enrolled, he or she needs to complete an Employee Application.
Access to care outside California

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

The BlueCard Program

For Blue Shield HMO and POS members
The BlueCard® Program provides members and their covered dependents access to medically necessary urgent and emergency care throughout the United States and worldwide. Members are not required to access emergency care through the BlueCard Program.

If members need emergency care services, they should seek care at the nearest medical facility and appropriately use the 911 emergency response system when it is available.

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

For Smart Shield PPO, Shield Savings Plus, and Active Choice® members
BlueCard provides members, and their covered dependents, access to medical care throughout the United States and worldwide.

Your health plan’s Evidence of Coverage or Certificate of Insurance describes member eligibility in the BlueCard Program. If your employees have questions about the BlueCard Program, please direct them to their member guides for a step-by-step process on how to use their BlueCard services.

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

* Underwritten by Blue Shield of California Life & Health Insurance Company.
Away From Home Care® program for HMO members

This program provides access to care for Access+ HMO® members and their covered dependents if they are:

• Long-term travelers who go outside California for a minimum of 90 consecutive days, but no more than 180 days, and return to their permanent residence.

• A family living apart, which applies to employees required by court orders to take responsibility for their dependents’ medical coverage; and the custodial parent or dependent child lives outside California.

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

• Students who are an employee’s dependents and who attend school and live outside the HMO service area, but whose principal residence is the employee’s permanent residence. Members can speak with a customer service representative about the Away From Home Care program by calling (800) 622-9402.

Please note these program restrictions

Away From Home Care benefits coverage will not extend beyond your group contract’s effective date, and program coverage is not automatic. It must be renewed annually.

To receive benefit coverage, members or their dependents living outside California must live in a Host Plan service area.

Members using Away From Home Care services outside California will receive the benefits offered by the Host Plan in the state they are visiting.
Ineligible individuals

These individuals are not eligible for Blue Shield group coverage:

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

Ineligible individuals for HMO/POS plans only:

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

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

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

Keep this helpful overview of enrollment procedures at your desk – simply print this page.

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

#### Quick reference guide for enrollment procedures

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<tr>
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<td>A copy of the court order; Employee Application; Eligibility Change Transmittal; or Self-Reporting Group Subscriber Report</td>
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</table>
Here’s a guide to help you easily understand the enrollment process so it goes smoothly for you and your employees.

**Annual open enrollment**

**What is open enrollment?**

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

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

During this time:

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

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

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

If the employee decides to make a plan change, or add or delete dependents, the employee will have to complete a Subscriber Change Request form. Additional forms may be required depending on the circumstance. For example, if the employee has disabled children, they will need to submit a Declaration of Disability for Overage-Age Dependent Children form (C3674) or Refusal or Cancellation of Personal Coverage form (C13124) if the dependent is over-age and a full-time student or on a medical leave from a college or trade school.

For open enrollment information on:

- Dental coverage, see page 48
- Vision coverage, see page 51

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

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

**Employees who are absent during open enrollment**

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

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

**Adding dependents**

To add a dependent, you can easily add the dependent on Employer Connection. Simply log in at blueshieldca.com/employer, and select Update Dependent Status once you selected the member from the member roster. Then you can follow the steps online to add a new dependent.

**Using paper:**

An alternate way of adding a dependent would be to have the employee complete and submit the Subscriber Change Request form. Please make sure that HMO and POS members select a Personal Physician for each dependent.
To add a newborn child, employees must complete and submit the Subscriber Change Request form within 31 days from the child’s date of birth. For the first 31 days, HMO members must select a Personal Physician for the child who is with the same IPA or medical group as the mother’s Personal Physician. After 31 days, the newborn child will be considered a late enrollee. (See page 31 for more information on late enrollment.)

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

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

1. Verify that the addition meets eligibility requirements.
2. Make sure the form is properly completed, signed, and dated.
3. Give the employee a copy of the completed form.
4. List the employee’s name and Social Security number (or any other identification number) on the Eligibility Change Transmittal or the Self-Reporting Group Subscriber Report.
5. Mail or fax the Subscriber Change Request form and the Eligibility Change Transmittal (or the Self-Reporting Group Subscriber Report) to the address listed in the Appendix.

**Selecting a Personal Physician (HMO and POS plans only)**

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

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

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

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

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

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

To print a directory, go to blueshieldca.com, click on I’m an Employer, then select Order Printed Materials under Employer Forms, followed by Customized Provider Directories. You can then personalize each directory based on plan type, and the directory will be available to you within minutes. Or, members can call the phone number on their ID card to request a directory.
Member ID cards
The member ID card identifies your employee as a Blue Shield member. If you offer dental HMO or dental PPO coverage, a separate ID card will be issued. Your employees should carry their Blue Shield ID cards with them at all times.

To order additional cards or print a temporary ID, members can log in to blueshieldca.com, click on My Health Plan or View Plan Summary, then select Order Blue Shield ID Cards, or call the number on their Blue Shield ID card.

If they have lost their card, they can call Member Services. Please see the “Whom to contact for answers” section on page 8.

HMO ID card sample

PPO ID card sample
Blue Shield will issue a combination medical and prescription drug ID card to members within two weeks after they enroll in your Blue Shield group plan.
Evidence of Coverage or Certificate of Insurance

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

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

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

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

Late enrollment

Managing late enrollment

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

• A late enrollee must wait until your company’s next open enrollment period to obtain coverage if he or she later decides to enroll.
• Blue Shield will not consider requests to be added for an earlier effective date. The same rules pertain to dependents of late enrollees who request enrollment after the initial enrollment period.

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

• Following the birth of a newborn, the adoption of a child, or a Qualified Medical Child Support Order (QMCISO)
• After marriage
• After the establishment of a domestic partnership
• After the loss of eligibility of other coverage

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

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

Exceptions to late enrollment

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

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

1. Employment of the original plan subscriber (such as the employee’s spouse or domestic partner) is terminated.
2. Employment status of the original plan subscriber (such as the employee’s spouse or domestic partner) changes. For example, the employee’s spouse begins working as a part-time employee rather than a full-time employee.
3. The other group-sponsored coverage is terminated.
4. The company sponsoring the other group-sponsored health plan is no longer contributing to coverage. For example, if your employee’s spouse’s company stops contributing to coverage under its health plan, your employee could apply for Blue Shield coverage and would not be considered a late enrollee.
5. The original subscriber of the employee’s health coverage dies.
6. Your employee gets a divorce from the original subscriber of the other group coverage.

The employee must request enrollment in a Blue Shield group plan within 31 days of losing the other group-sponsored coverage, Medi-Cal, or Healthy Families Program eligibility.

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

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

Please note: A dependent is not considered a late enrollee if a court orders the employee to provide medical coverage for a spouse or minor child or the dependent loses his or her coverage under Medi-Cal or the Healthy Families Program.

Initial enrollment for new employees

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

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

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

This is a period when the employer can:

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

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

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

**Credit for prior coverage and pre-existing condition limitations**

Blue Shield will credit any pre-existing condition limitation waiting period by one month for every month of prior coverage, as long as a break in coverage does not exceed 63 days from the prior individual plan or six months from the prior employer-sponsored group plan. An employer’s eligibility waiting period is not counted as a break in coverage.

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

Pre-existing condition limitations will be calculated based on the employee’s enrollment date with the plan, which includes any employer waiting period. Also, Blue Shield will not apply pre-existing condition limitations to pregnancy or maternity care or to newborn and adopted children who do not have a break in coverage more than 63 days and are enrolled within 30 days after birth or adoption.

Pre-existing condition limitations do not apply to HMO or POS plans.

**For groups that have renewed after September 23, 2010:**
Under the Patient Protection and Affordable Care Act, no pre-existing conditions may be excluded on coverage for any enrollee under the age of 19.

**For groups that haven’t yet renewed after September 23, 2010:**
Upon renewal on or after September 23, 2010, all Blue Shield of California and Blue Shield of California Life & Health Insurance Company group plans and policies that have a pre-existing condition limitation will be modified to remove pre-existing limitations for enrollees under the age of 19.

A **pre-existing condition limitation** is an illness, injury, or condition (including total disability) which existed during the six months prior to the enrollment date of coverage if, during that time, any medical advice, diagnosis, care, or treatment was recommended or received from a licensed health practitioner.
Employee status changes

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

You can make member address changes by submitting a request by email to largegroup.memberrequests@blueshieldca.com or by calling your Large Group Client Services representative at (800) 837-4215.

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

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

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

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

The length of a leave of absence is according to your company’s personnel policy. Therefore, your company’s policy determines when the employee on leave is terminated. You must notify Blue Shield when you terminate the employee by submitting the information by email to largegroup.membereligibility@blueshieldca.com or by calling your Blue Shield group billing representative at the number on your billing statement. When an employee on leave is terminated, the individual may qualify for continuation coverage in the same manner as a terminated employee who was actively working on his or her last day of coverage.

Divorce or legal separation
When a member divorces, his or her dependent children do not lose eligibility, and may continue to be covered as the employee’s dependents. If the employee decides to cancel the children’s group coverage, they may elect COBRA on their own within the 60-day election period.

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

For more information, see the Coverage cancellation and options for employees section on page 37.

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

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

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

Non-preferred providers
(for PPO medical plans only)
If a non-preferred provider asks the member for payment immediately after the visit, the member should:

• Pay the bill; then
• Mail the itemized bill along with a Subscriber’s Statement of Claim form to Blue Shield.

Members should send Blue Shield a claim form for all covered services, even if they have not yet met their calendar-year deductible. This allows us to accurately keep track of members’ deductibles. Blue Shield will reimburse the member for the plan-covered benefit payment less the deductible and copayment amount.

Explanation of Benefits (EOB)
An EOB explains the actions taken on each claim a member or provider submits. The EOB tells a member how a submitted claim was processed and informs the member of his or her financial responsibility. The EOB is not a bill. However, it will reference any copayments the member owes for services (see page 65 for a sample EOB).

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

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

Employees can reference their Evidence of Coverage or Certificate of Insurance for a detailed process overview about how to file a grievance, or log in to I’m a Member at blueshieldca.com and click on File a Grievance under I’ve Had Care.
Coverage cancellation and options for employees

Employees or dependents who no longer qualify for your group’s Blue Shield coverage may be eligible for extended coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or Cal-COBRA. Please advise your employees who are thinking of continuing group coverage under COBRA or Cal-COBRA to consider these options carefully before investigating individual health insurance. Companies that sell individual coverage require a review of an applicant’s medical history that could result in a higher premium or a complete rejection.* And, an individual is not eligible for an individual conversion plan (ICP) or a guaranteed-issue individual plan as required by federal law (HIPAA) unless all group coverage options are exhausted including COBRA and Cal-COBRA.

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

- Report coverage cancellations of members who are no longer eligible
- Notify us prior to each individual’s last day of eligibility, whenever possible, by calling Large Group Client Services or by filling out an Eligibility Change Transmittal form

Alternatively, you may cancel an employee by following these steps:

- Fill out an Eligibility Change Transmittal form.
- List the employee’s name, Blue Shield ID number or Social Security number, and employment termination date.
- Mail, fax, or email the Eligibility Change Transmittal to Blue Shield.
- Cancellation requests must be submitted within 30 days of the termination date. Blue Shield will only give up to one month of credit unless subject to the provisions in Part III Eligibility of your group contract.

Helpful hints

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

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

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

Cancelling employee and dependent coverage

Employee coverage cancellation

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

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

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

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

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

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

- A spouse who divorces or legally separates from a covered employee and becomes ineligible for group coverage.
- The subscriber’s dependent children, if the subscriber decides to cancel the dependent children from his or her coverage.
- A domestic partner and his or her children. When a domestic partnership terminates, group coverage of the employee’s domestic partner and his or her children will terminate at the end of the month in which the domestic partnership termination occurs. The employee’s domestic partner and children may be eligible for continued coverage under Cal-COBRA. For details, see the “Employee status changes” section on page 34.

Please note: Federal COBRA does not require continued coverage for the same-gender spouse or children when the divorce occurs because a same-gender spouse is not considered a legally married spouse under federal law.

Employees are responsible for informing you when a dependent is no longer eligible for coverage. To cancel a dependent’s coverage when the employee continues to be covered, follow these steps:

1. Have the employee complete a Subscriber Change Request form (see page 57) and list the name(s) of the dependent(s) to be disenrolled and the date(s) of cancellation. The employee should complete this form during the month the dependent becomes ineligible for coverage.

2. Verify that the form is properly completed, signed, and dated, and give the employee a copy of the form.

3. List the employee’s name and Subscriber ID number on the Eligibility Change Transmittal.

4. If your group is self-reporting and doesn’t receive a billing statement, enter the employee name on the Self-Reporting Group Subscriber Report and the dependent dues/premiums in the “Current Dues Deletions” column. Under “Remarks” note that a dependent is being disenrolled and indicate the effective date.

5. Mail, fax, or email the Subscriber Change Request and Eligibility Change Transmittal/Self-Reporting Group Subscriber Report to Blue Shield.

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

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

General guidelines

COBRA
Applies to employers that employed 20 or more employees during at least 50% of the working days in the previous calendar year.

When the number of employees either increases to more than 19 or decreases to less than 20, you must wait until the first of the next calendar year and use the above guidelines before changing your administration of continuation of group coverage from Cal-COBRA to COBRA or from COBRA to Cal-COBRA. 

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

COBRA coverage
Blue Shield does not provide federal COBRA administrator services. All employers are responsible for administering their own federal COBRA program.

Groups have the option to self-administer their federal COBRA benefits, choose a third-party COBRA administrator, or go with Blue Shield’s preferred COBRA administrator, CONEXIS. For more information, contact CONEXIS at [877] 266-3947 or bscsales@conexis.com, or visit their website at www.conexis.org.

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

1. The member is determined to be disabled on or before the date of termination or has a reduction in hours of employment; or
2. The member is determined to be disabled within the first 60 days of the initial qualifying event; and
3. Notification is given to the employer or Blue Shield before the end of the 18-month COBRA coverage period. The member is responsible for notifying the employer or Blue Shield within 30 days of any final determination affecting the member’s – or the member’s dependents’ – disability status.

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

Cal-COBRA coverage for COBRA enrollees
Enrollees who reach the 18-month or 29-month maximum available under COBRA may elect to continue coverage under Cal-COBRA for a maximum period of 36 months from the date the person’s continuation coverage began under COBRA. These conditions apply:

• If elected, the Cal-COBRA coverage will begin after the COBRA coverage ends and will be administered by Blue Shield’s Cal-COBRA Administration.

• COBRA enrollees must exhaust all the COBRA coverage to which they are entitled before they can become eligible to continue coverage under Cal-COBRA, with the exception of domestic partners when the partnership terminates and same-gender marriages when divorce occurs.
- When the domestic partnership terminates, the same-gender spouses are divorced, or the employee dies, the domestic partner or same-gender spouse may apply for continuation of group coverage under Cal-COBRA.

- Cal-COBRA coverage is immediately available because a domestic partner and a same-gender spouse do not have COBRA eligibility unless the employee elects and remains enrolled in COBRA and includes the domestic partner or the same-gender spouse as a dependent.

How to enroll in Cal-COBRA

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

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

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

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

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

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

Individual conversion plan (ICP)

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

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

Health Insurance Portability and Accountability Act (HIPAA) guaranteed issue

Former employees that have elected and exhausted COBRA and/or Cal-COBRA coverage may qualify for an Individual and Family Plan (IFP) on a guaranteed-issue (GI) basis. The HIPPA GI plan is only available if the former employee satisfies these additional requirements:

- Had at least 18 months of creditable coverage
- The most recent coverage was group coverage (COBRA and Cal-COBRA are considered group coverage)
- Applies to Blue Shield for GI coverage within 63 days of the date of termination from the group plan.

(Former employees under the age of 19 are eligible for guaranteed issue under any individual plan as long as general eligibility requirements are met.)

Extension of benefits for disabled members

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

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

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

(Members under the age of 19 are not subject to a pre-existing condition exclusion.)

Members may contact Direct Sales at (800) 910-1010 to inquire.

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

Filing for an extension of benefits for disabled members

To file for an extension of benefits:

- The employee must complete a Subscriber Statement of Disability form; and
- You must complete a Notice of Total and Permanent Disability form and then mail both forms to Blue Shield; and
- The Personal Physician must submit an Attending Physician Statement of Disability form to Blue Shield.
Coverage options for employees and retirees who have Medicare coverage

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

**Active employees**

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

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

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

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

Employer groups that provide prescription drug benefits to Medicare Part D eligible individuals must submit the online disclosure form directly to CMS. If the employer group does not provide prescription drug benefits to any Medicare Part D eligible individual, no disclosure form needs to be completed for the plan year.

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

**Medicare claims appeal process**

Members enrolled in Blue Shield 65 Plus may contact the Member Services department seven days a week from 7 a.m. to 8 p.m. at (800) 776-4466 [TTY: (800) 794-1099] to appeal already adjudicated claims.

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

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

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

Table 4

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

Standard positive billed groups

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

You should:

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

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

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

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

If you have any questions about changes to your group’s coverage, please contact your Large Group Client Services representative at (800) 837-4215.

Coverage from Blue Shield is offered on a prepaid basis. Blue Shield must receive your group’s dues on or before the due date to keep your coverage current. An “unpaid” status could cause your group’s coverage to be suspended or cancelled.

Reporting changes, additions, and deletions to your group’s coverage in a timely manner will help avoid unnecessary delays.

Paying dues for new additions

You do not need to pay dues for new employees or dependents until Blue Shield bills you for any additional dues on your next billing statement. Please note that the benefit administrator is responsible for verifying that the request is being processed by reviewing your billing statement each month. If the requested changes are not reflected on your invoice within two months, please contact your Billing Team at the phone number on your billing statement.

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

If an employee is terminated during the month:

- Please submit an Eligibility Change Transmittal immediately after the employee’s termination date.
- The employee’s coverage will remain in force until the end of the billing period and dues are payable for that period.
- The terminated employee will be deleted from the next billing statement.
- If you report coverage cancellation of an employee or dependent and it doesn’t appear on your next monthly bill, do not make any billing adjustment. Simply pay the total that appears on your current billing statement and Blue Shield will credit you for the deleted dues on your next billing statement. If any submitted changes do not appear within two billing cycles, contact your group billing representative at the number listed on the billing statement.

**Identifying class and plan transfers**

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

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

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

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

Important points for you to remember about the Self-Reporting Group Subscriber Report

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

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

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

Eligibility file procedures

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

Audit file procedures

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

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

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

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

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

• The alternative is to submit an Excel file by email. Do not send printed reports as they can not be processed.

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

• Blue Shield will provide a discrepancy report within 10 business days to the group or third-party administrator (TPA).

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

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

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

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

The delinquent notification policy and procedures are listed below:

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

Late-payment notice for delinquent groups

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

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

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

Group cancellation procedures

Requesting cancellation of your group account

Blue Shield requires 30 days’ advance notice of cancellation in writing. Notification can be sent by one of two options:
1. By sending a letter on business letterhead; or
2. By making a notation on your billing statement.

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

Nonpayment of dues

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

- Blue Shield will send you a Prospective Notice of Cancellation 15 days after the due date to notify your group of the delinquent status. This notice serves as the 15-day notice of cancellation as required by state law. If payment of all outstanding dues is not received within 15 days after mailing the Prospective Notice of Cancellation, the account will be cancelled for nonpayment of dues on that date. The effective date of the cancellation will be 30 days after the bill due date listed on your Group Request unless requested otherwise.

- Blue Shield will then mail you a notice confirming termination of coverage. You must promptly notify your employees of the cancellation of your employer group plan by providing them with a copy of this notice. If your account is cancelled, benefits will not be provided for any services incurred by your employees and dependents after the cancellation date.

- The contract will not be reinstated, and Blue Shield requires that the employer complete a new application for coverage.
- A new contract will be issued only upon demonstration that the employer meets all underwriting requirements.
- The employer will remain financially responsible for all outstanding dues incurred while the account was in effect.

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

The following is designed to make it easier for you to enroll and manage your group dental plan if you’ve selected Blue Shield dental coverage for your employees. By purchasing dental coverage along with your Blue Shield medical plan, you enjoy the advantages of joint administration:

• Single enrollment form
• Single point of contact for adding and removing employees and their dependents
• Single bill for medical and dental PPO plans

Enrolling employees and dependents

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

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

Employee status change

You are responsible for maintaining accurate eligible employee information.

• A Subscriber Change Request form (C675-1) must be completed when there is a change in status to an employee, or their dependents, spouse, or domestic partner.

• In cases of births, adoptions, marriages, and divorces, the employee must submit the Subscriber Change Request form no later than 31 days after the change.
• If the employee does not submit the form no later than 31 days after the change, they will need to wait until your group’s next open enrollment period.
• If the employee decides to add coverage for an existing dependent or spouse, the employee must wait until your group’s next open enrollment period.
• Employees with family coverage should notify Blue Shield when a dependent child reaches age 26.

Invoice procedures

Membership changes should be faxed or mailed to Blue Shield prior to the 15th of each month to be reflected on the following month’s invoice and Add/Change/Terminate Report. It is important to pay the amount shown on the invoice. Please do not subtract terminating employees’ dues from the amount due as it will result in a negative balance on the next month’s bill. The termination information should be submitted on the Employee Change Transmittal form (C3843). The amount will then be credited on the next billing, and the account will remain current.

Open enrollment

Approximately 45 days prior to your group’s renewal date, you should schedule an open enrollment period to help the employee understand their benefits and options. For assistance in planning your group’s open enrollment period, please contact your producer or Blue Shield sales representative.
Dental HMO provider change
Dental HMO members may change their current dental provider at any time by calling Dental Member Services at (800) 585-8111.
Changes are effective the first day of the following month a request is received.

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

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

Nationwide dental provider network
In addition to the large California provider network, the national network* helps meet the needs of California employers who have out-of-state employees. Blue Shield offers all members with dental coverage access to a nationwide dental provider network to receive care from preferred dental providers – just like employees in California.
Members can identify whether a particular dentist is in the provider network or get a listing of providers in the Blue Shield dental PPO or HMO network by:
• Going to blueshieldca.com to find a provider
• Calling Dental Member Services at (800) 585-8111 to request an HMO dental provider directory or (888) 702-4171 to request a PPO dental provider directory

Forms
Forms for administering group dental benefits are listed on page 58. You can print them from blueshieldca.com or order them by contacting your Blue Shield sales representative.

Dental Member Services
Dental Member Services can assist you with questions about eligibility, claims, or ordering forms and/or directories. For questions about your plan or renewal rates, please contact your Blue Shield sales representative.

Dental Member Services
Dental HMO: (800) 585-8111
Dental PPO: (888) 702-4171
Monday – Friday, 5 a.m. to 8 p.m. PST

* Dental providers nationwide and in California are available through a contracted dental plan administrator.
Grievance process

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

Blue Shield of California
Dental Plan Administrator
425 Market Street, 12th Floor
San Francisco, CA 94105

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

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

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

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

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

Enrolling employees and dependents

As new employees, their spouse/domestic partner, and their dependents, become eligible for benefits, or once they have fulfilled your company’s benefits waiting period, they should complete a new Employee Application (C15390) or the Vision Only Enrollment form (ABU1189).

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

Employee status change

You are responsible for maintaining accurate eligible employee information.

• Each month you will receive a premium billing statement, which includes all eligible members for the next month. Review your premium billing statement to confirm accurate eligible employee information.

• A Subscriber Change Request form (C675-1) must be completed when there is a change in status to an employee’s dependents, spouse, or domestic partner.

• For terminations, use the Employee Change Transmittal form (C3843).
  – Complete and return the Eligibility Control form included with your bill with any enrollment changes. You can submit this form each month noting the enrollment changes.

Invoice procedures

Membership changes should be faxed or mailed to Blue Shield prior to the 15th of each month to be reflected on the following month’s invoice and Add/Change/Terminate Report. It is important to pay the amount shown on the invoice. Please do not subtract terminating employees’ dues from the amount due as it will result in a negative balance on the next month’s bill. The termination information should be submitted on the Employee Change Transmittal form (C3843). The amount will then be credited on the next billing, and the account will remain current.

Open enrollment

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

Nationwide vision provider network

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

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

Vision plan information card

Each member can receive a vision plan information card for use when seeking services. The card is not required, but has useful information for both the member and the provider. Cards will be included with new enrollment materials, and additional cards can be printed from our website. Go to blueshieldca.com/employer and click on Vision Plans. Or, you can call Customer Service for assistance at (877) 601-9083.
**Submitting a claim**

A claim form is not necessary when using a network provider. When using a non-network provider, the employer, employee, and/or provider may be required to complete a Vision Claims form (C-4669-61). Please refer to the claim form to determine which areas will need to be completed. Members may be expected to pay the full amount when using a non-network provider. They will be reimbursed after submitting a claim form.

Mail completed claim form(s) and documentation to:

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

**Forms**

Forms for administering group vision benefits are listed on page 58. You can print them from blueshieldca.com or order them by contacting your Blue Shield sales representative.

**Vision Member Services**

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

**Grievance process**

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

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

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

Please note: If an employer’s health plan is governed by the Employee Retirement Income Security Act (“ERISA”), employees may have the right to bring civil action under Section 502(a) of ERISA if all required reviews of a claim have been completed and a claim has not been approved.
How to manage your group life insurance benefits

The following is designed to make it easier for you to enroll and manage your group term life insurance plan. By purchasing life and AD&D insurance coverage along with your Blue Shield medical plan, you receive advantages of joint administration:

- Single enrollment form for both medical and life
- Single point of contact for adding and deleting employees and dependents
- Combined billing statement for your medical and life insurance rates, unless you self-report your life insurance billing

Enrolling employees and dependents

All employees who are electing a Blue Shield medical plan, Blue Shield life insurance, and AD&D coverage should complete a Blue Shield Employee Application, with the “Life Insurance Beneficiary” section completed. Employees waiving medical plan coverage should use the same application electing “Life only” and complete the “Life Insurance Beneficiary” section. All completed applications should be submitted to the health plan billing representative.

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

Employee status change

You are responsible for maintaining accurate eligible employee information.

- You are responsible for maintaining copies of any completed Employee Application and Beneficiary Change form (ABU1165).
  - You provide these beneficiary designation and affidavit forms directly to the Blue Shield life insurance claims department only when submitting a life insurance and AD&D insurance claim, or waiver of premium claim.
  - You are responsible for maintaining Statements of Domestic Partnership, if applicable.

Invoice procedures

Membership changes should be faxed or mailed to Blue Shield Life prior to the 25th of each month to be reflected on the following month’s invoice and Add/Change/Terminate Report. It is important to pay the amount shown on the invoice. Please do not subtract terminating employees’ dues from the amount due as it will result in a negative balance on the next month’s bill. Termination information should be submitted on the Employee Change Transmittal form (C3843). The amount will then be credited on the next billing cycle.

Certificate of Insurance

- Certificates of Insurance are automatically generated and mailed to each employee as they are enrolled under your policy. If you are set up for self-billing for life premium, you will receive standard Certificates of Insurance for distribution to covered employees.
- Questions about Blue Shield Life Certificate of Insurance should be directed to your health plan billing representative, or call Blue Shield Life Group Insurance at (888) 800-2742.

How to submit a waiver of premium claim

If your employees become totally and continuously disabled before age 60, they may be eligible for a waiver of premium. Proof of total, continuous disability must be received by Blue Shield no later than 12 months following the onset of disability and no longer than six months after the life insurance policy terminates.

The following documents are required:

- Waiver of Premium claim form (ABU1182) completed by employer, employee and/or attending physician

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).
• Attending Physician Statement of Disability (CP1012-LO)
• Proof of current beneficiary designation
• Two months’ pay stubs showing number of hours the employee has worked

Once approved, life insurance coverage will remain in force until the earliest of the following:
• The subscriber is no longer disabled; or
• The subscriber has not provided suitable written proof of continued disability as required by us; or
• The subscriber refuses to be examined by a physician when required by us; or
• The subscriber attains an age or retirement status as specified in the contract.

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

Waiver of premium may be converted when the benefits are terminated, and at the subscriber’s request. The application for conversion must be made within 31 days of termination of coverage. Only amounts $2,000 or higher are eligible for conversion.

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

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

How to submit a life or an accelerated death benefit (ADB) claim
If one of your employees becomes terminally ill before the age of 60, they may be eligible to withdraw an ADB benefit, subject to the following minimums and maximums:
• Maximum allowed is 50% of benefit or $250,000, whichever is lower.
• Minimum allowed is 10% of benefit or $5,000, whichever is greater.
• Minimum of $15,000 in coverage is required to receive ADB.

The following documents are required:
• An Accelerated Death Benefit claim form (ABU1139) completed by the employer, employee, and/or attending physician is required
• Two months’ pay stubs showing number of hours the employee has worked

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

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

Blue Shield Life Member Services
Phone: (888) 800-2742
Fax: (800) 329-2742
Monday – Friday, 9 a.m. to 5 p.m. PST
How to submit a life or accidental death claim

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

- Proof of Death claim form (ABU1180)
- Original certified death certificate
- Original Group Life Insurance Plan Employee Enrollment form
- Any change of beneficiary forms since enrollment, if applicable
- In cases of accidental death, the official investigative report (i.e., police, accident, fire, FAA, OSHA), autopsy report, toxicology report, and/or any medical records requested by Blue Shield

Interest on life insurance policies is based on California Insurance code 10172.5. The code states that if we cannot pay the benefits within 30 days of the date of death, for whatever reason, we must pay interest. Interest is calculated at 3% from the date of death to the date on the payment letter and check.

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

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

Mail Proof of Death claim form and documentation to:

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

How to convert from term life to whole life

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

The entire amount of group term life coverage lost can be converted. Exceptions to conversion are as follows:
- Upon termination or amendment of the group policy; or
- The employee requested termination of the group life insurance or cancelled the payroll deduction for the life insurance; or
- As prohibited by state law.

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

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

Applicants should complete and submit an Individual Conversion Life Insurance Policy application form (CP1020) within 31 days of the termination or benefit reduction in order to be eligible for the conversion policy. After 31 days, the application will be declined.

The premium will be greater than what was charged under the group plan, since group insurance is less expensive than individual insurance, and the employee will be billed individually for the coverage. The premium rate is based on the age of the applicant and the
amount being converted. Premium information can be found on page 2 of the Individual Conversion Life Insurance Policy application.

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

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

Mail the Individual Conversion Life Insurance Policy application form to:

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

1 If the employee meets the definition of “disabled” under the terms of the life insurance policy, they may be eligible for the waiver of premium benefit. If approved, the waiver of premium benefit would begin after the benefit’s waiting period. While the group coverage remains in force, the group will not be billed for the coverage. Further, a subscriber may choose to apply for a life conversion if the employer terminates the subscriber’s coverage before they are eligible (or approved) for waiver of premium or upon the termination of the waiver of premium benefit.

Forms
Forms for administering group life insurance are listed on page 58. You can print them from blueshieldca.com or order them by contacting your Blue Shield account manager.

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

Grievance process
Members may contact Life/AD&D Member Services by telephone or letter to request a review of an initial determination concerning a claim or service. Members may contact Life/AD&D Member Services at the telephone number listed on this page. If the telephone inquiry to Life/AD&D Member Services does not resolve the question or issue to the member’s satisfaction, the member may submit a formal grievance at that time. The Life/AD&D Member Services representative can initiate a grievance on the member’s behalf. The member may also initiate a grievance by submitting a letter or a completed grievance form. The member may request this form from Life/AD&D Member Services. If the member wishes, Life/AD&D Member Services can assist in completing the grievance form. Completed grievance forms must be mailed to the Life/AD&D Plan Administrator at the address below:

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

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

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

To get copies of forms listed or any additional forms, go online to blueshieldca.com and click on I’m an Employer. There you’ll find all employer and employee forms available to print at your convenience. If you need assistance, contact your Blue Shield sales representative.

**Employer forms**

**Changes and terminations**

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

**Employee forms**

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

**Additions, deletions, and other changes**

**Health plans**

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

**Subscriber forms**

<table>
<thead>
<tr>
<th>Form Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Subscriber Change Request (C675-1-ML)</strong></td>
<td>Employees must complete this form any time they make changes to their personal information or any type of coverage changes, such as adding or deleting dependents.</td>
</tr>
<tr>
<td><strong>Subscriber Statement of Disability (C12198)</strong></td>
<td>To file for an extension of disability benefits, employees must complete this form. In addition, benefit administrators need to complete a Notice of Total and Permanent Disability form.</td>
</tr>
</tbody>
</table>
Employee forms

Additions, deletions, and other changes (continued)

Life insurance plans

Authorization for Blue Shield of California Life & Health Insurance Company to Disclose Personal & Health Information to a Third Party (C15625)

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

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

Additional contact designation form (C45466)
Notice of Lapse or Termination of Life Insurance Policy for Non-payment of Premium.

Federal COBRA elections

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

Claims

Health plans

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

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

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

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

Dental plans

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

Vision plans

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

Claims (continued)

Life insurance plans

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

**Life & AD&D Waiver of Premium Claim (ABU1182)**
Employer, employee, and attending physician will need to complete this form for insured employees who become disabled before age 60.

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

Other

**Vision Plan Information Card ABU15756-CA (for California members) ABU15756-OOS (for members outside California)**
The card is not required, but has useful information for both the member and the provider.
Group summary bill

**Group and subgroup numbers**
You will find a group and subgroup numbers embedded within the account number located under the mailing address on your first month’s bill. Your account number is “1” followed by your group number beginning with the letter “W” and followed by seven numbers, then followed by your subgroup number, which is 4 numbers.

Example:

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

**New integrated bill format**

A  Bill date  
B  Billing period and due date  
C  Previous amount due  – The total amount due from the prior month’s billing statement  
D  Payment  – Payment received since last billing statement
Sample Group Summary Bill

Blue Shield of California
Installation & Membership - Large Group
P.O. Box 629014
El Dorado Hills CA 95762-9014

COMPANY
JANE SMITH
300 SAMPLE AVE STE 100
CITY, ST 90034

ACCOUNT NUMBER: 1234567890
INVOICE NUMBER: 1234567890

Dear

Blue Shield of California is a prepaid health plan. Payment is due by the Due Date referenced above.

There is a grace period for payment that ends 30 days after dues/premiums are due. If the current charges due are not received by 01/29/13, your group health coverage may be cancelled for non-payment of dues/premiums. This bill does not include any payments that may have been made after the Bill Date listed above.

Thank you for your continued membership with Blue Shield. We appreciate the opportunity to serve you and provide you with access to quality healthcare. Please contact us if you have any questions.

Please pay the total amount due.

Sincerely,

Billing Representative
Blue Shield of California

www.blueshieldca.com

Eligibility Inquiries: (800) 325-5166
Billing Inquiries: (916) 350-7693
Medical Claims Inquiries: (888) 256-1915
Dental Claims Inquiries: (888) 702-4171
Vision Claims Inquiries: (877) 801-9081
Life Insurance Claims Inquiries: (888) 800-2742

Please return the portion with payment to the address listed below

Group Name: TOPSON DOWNS OF CALIFORNIA INC
Account Number: 1W00022831000
Invoice Number: 123460218829

Please remit payment to:

BLUE SHIELD OF CALIFORNIA
P.O. BOX 749415
LOS ANGELE CA 90074-9415

Total Due - please pay this amount $ 279,139.09
Due Date-Please pay within 15 days.
Amount Enclosed

12/01/12
New integrated bill format

Blue Shield of California
Installation & Membership - Large Group
P.O. Box 629014
El Dorado Hills CA 95762-9014

Account Number:
Invoice Number:

<table>
<thead>
<tr>
<th>Contract Type</th>
<th>Subscriber Count</th>
<th>Current Charges</th>
<th>Adjustments</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shield Spectrum PPO (SM) 250-80/60 Standard - Blue Shield of California Life &amp; Health insurance Company</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>17</td>
<td>12,784.34</td>
<td>0.00</td>
<td>$12,784.34</td>
</tr>
<tr>
<td>2 Party</td>
<td>3</td>
<td>4,737.66</td>
<td>0.00</td>
<td>$4,737.66</td>
</tr>
<tr>
<td>Family</td>
<td>4</td>
<td>9,023.32</td>
<td>0.00</td>
<td>$9,023.32</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>26,545.32</td>
<td></td>
<td>$26,545.32</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contract Type</th>
<th>Subscriber Count</th>
<th>Current Charges</th>
<th>Adjustments</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td></td>
<td>130,097.48</td>
<td>0.00</td>
<td>130,097.48</td>
</tr>
</tbody>
</table>

Membership Summary

Total Current Adjustments
- Net Change Subscribers: 0
- Net Change Members: 0

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

Total Subscribers: 250
Total Members: 49

Billing Detail

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

Current Charges
Employee Application quick guide

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

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

### Critical fields

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last name, first name</td>
<td>Full name of enrolling employee; middle initial is optional</td>
</tr>
<tr>
<td>Mailing address</td>
<td>Member communication, including ID card, will be mailed to this address.</td>
</tr>
<tr>
<td>Full-time hire date</td>
<td>Date of full-time status, working 20 or more hours per week</td>
</tr>
<tr>
<td>Date of birth</td>
<td>Month, day, and year of birth</td>
</tr>
<tr>
<td>Sex (gender)</td>
<td>Male or female</td>
</tr>
<tr>
<td>Job title</td>
<td>Required if eligibility is based on job title</td>
</tr>
<tr>
<td>Social Security number</td>
<td>Nine-digit Social Security number required for both employees and dependents</td>
</tr>
<tr>
<td>Plan/benefit Information</td>
<td>Medical benefits and optional benefits chosen</td>
</tr>
<tr>
<td>Dependent information</td>
<td>Relationship, gender, first name, last name (if different from the enrolling employee), date of birth, and benefit option (medical/dental). If the enrollee has an over-age (older than 26) disabled dependent, a Declaration of Disability for Over-Age Dependent Children form must be included.</td>
</tr>
<tr>
<td>Certification for students over age 18</td>
<td>Name and number of course units</td>
</tr>
<tr>
<td>Signature of employee and date</td>
<td>Employee’s signature and date signed on the Authorization section</td>
</tr>
</tbody>
</table>

### Important fields

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

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

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

1. Patient’s responsibility amount
2. Claims details
3. Detailed grid that clarifies amount allowed versus amount billed
4. Helpful definitions
5. Claims Summary at a Glance box:
   - Displays patient responsibility amount and deductible status
   - Summarizes key information

Sample EOB

Thank you for choosing Blue Shield.

To use the extra services and support available to you, go to www.myblueshield.com.

4

Blue Shield of California

EXPLANATION OF BENEFITS

This is NOT a Bill

Return your records along with any provider bills.

Your claim information is also available in the MyHealthPlan section of www.myblueshield.com. If you have any questions about the document or your benefits, please call us at 1-800-208-2424.

Your covered services are described below. Your provider billed for the following services, which you authorized.

Your coverage and benefits may vary. If you have any questions, please contact your provider or Blue Shield of California.

Blue Shield of California

EXPLANATION OF BENEFITS

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Your covered services are described below. Your provider billed for the following services, which you authorized.

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Sales contact information

**Northern California**

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

**Sacramento**
4203 Town Center Blvd.
El Dorado Hills, CA 95762
(916) 350-7790

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

**San Jose**
1735 Technology Drive, Bldg. 4, Suite 100
San Jose, CA 95110
Phone: (408) 452-6900
Fax: (408) 452-6910

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