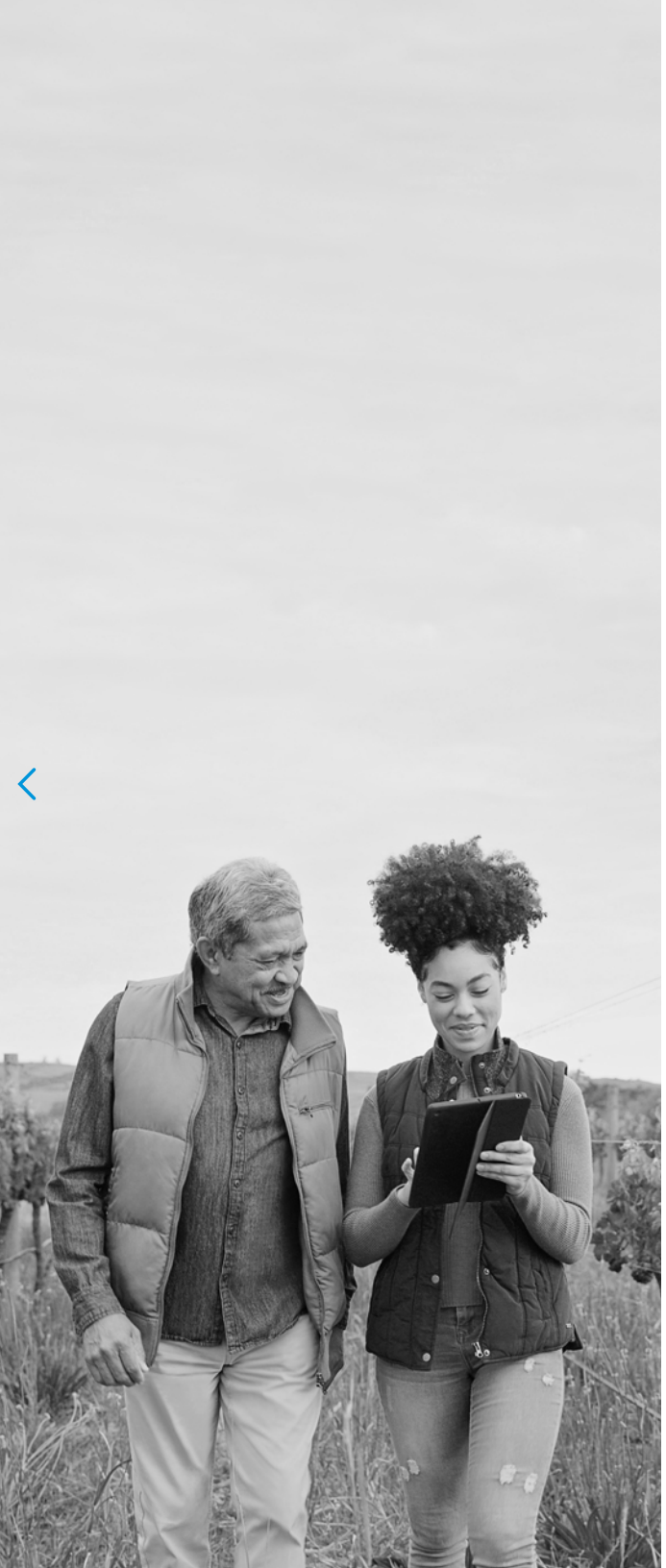
blue california

Small Business administrator's guide

For Small Businesses with 1 to 100 employees

blueshieldca.com/employer

Effective January 1, 2023



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Welcome to Blue Shield

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

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

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Getting started

Online resources

Get the most from Employer Connection

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

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

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

Manage your account online

Benefit administrators can register for online account access at blueshieldca.com/employer. Once there, you can securely log in 24/7 to:

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

Conduct open enrollment online

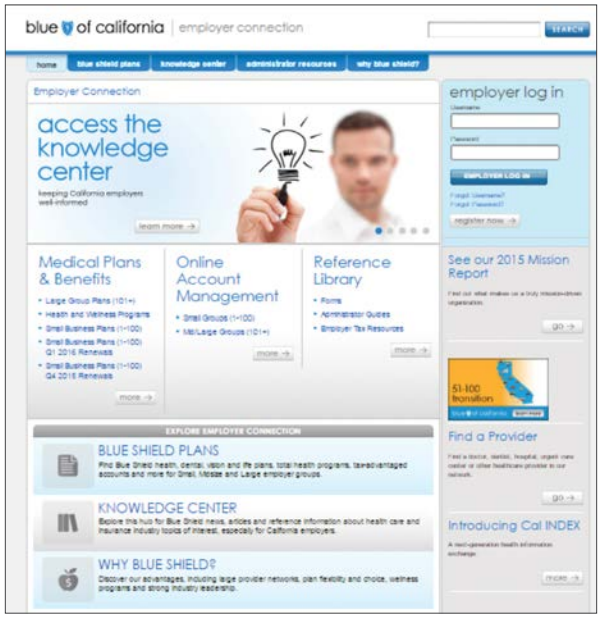
If your employees do not want to make a change, they do not have to do anything but simply pay their bill at the new rate.

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

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

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

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



Pay your bill online

Autopay makes billing easy

Signing up for automatic payments is a great way to save time and effort when it comes to monthly billing. We've made it easy for you to sign up for autopay through Employer Connection. As long as there's zero balance with no payment due, all you need to do is follow these steps to sign up:

- After logging in to the portal, hover over the BILLING tab at the top left of the home screen.
- Select BILLING OPTIONS from the drop-down menu.
- Enter your account information (checking or saving), and click the ADD ACCOUNT button.
- Return to the BILLING tab and select AUTOPAYMENTS from the drop-down menu.
- Start a new autopayment.
- Select your group number from the drop down, then select your payment account from the second drop down. Hit the SAVE button.

Please note: Currently, Blue Shield of California does not have a paperless billing option. Therefore, groups enrolled in autopay will still receive a paper statement every month.

For assistance, please contact Group Administrative Services by calling (800) 325-5166.

For your employees

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

Select My Plan to:

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

Select Find a Doctor to:

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

Select Find a Doctor Performance Profile to:

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

Select Be Well to:

- Learn about our Wellvolution® personalized diet and lifestyle programs and sign up at no additional cost. Programs are easy to use and offer structured plans, tools, coaches, and support to help members improve their health, lose weight, prevent or treat chronic conditions, and feel better
- Learn about the gym benefit, as well as health and lifestyle discounts
- Learn how to talk with a nurse by phone or online through our NurseHelp 24/7 program
- Use our health encyclopedia to research a condition or treatment
- Sign up for our monthly Health Update email newsletter filled with timely health and benefits information
- Download a copy of the Preventive Health Guidelines

Select Pharmacy (under Benefits) to:

- Search among our network of more than 5,400 retail pharmacies in California, one specialty pharmacy, and one mail service pharmacy. Employees can use Find a Pharmacy to locate the network pharmacy closest to them
- View the plan formulary, search for drugs, and view drug information
- Check drug costs
- Order up to a 90-day supply of covered maintenance medications online through our contracted mail service vendor and have them delivered directly to the employee's home or office

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

Eligibility

Eligibility requirements

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

Eligible employees

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

1. Full-time employees

Full-time employees are eligible for coverage if they:

- Work an average of 30 hours per week as permanent, year-round employees and are actively engaged in conducting your company's business
- Perform job duties at your company's usual place of business
- Receive wages, commissions, or a salary

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

2. Part-time and temporary employees

An employee working at least 20 hours, but not more than 29 hours, per normal work week on a permanent year-round basis is not eligible for group coverage unless your group contract provides benefits for all employees in this category under state law.

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

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

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

A group may add the part-time employee coverage option at any time during the year. If the option is requested outside of the group's renewal period, it will be effective on the first of the month following receipt of the request.

3. Sole owners or partners of a partnership

Owners or partners of a partnership are eligible for coverage if:

- They serve as full-time employees
- They work an average of 30 hours per week and actively engage in conducting your company's business
- They perform the job duties at your company's usual place of business
- They qualify as employees under your company's health coverage plan contract
- The group meets all small employer eligibility requirements

4. Rehired employees

The Small Business enrollment guidelines indicate that for employees rehired within six (6) months of cancellation of coverage, the effective date will be the date of rehire if the paperwork is received within 60 days of the rehire date and they:

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

For employees rehired within the six-month window, the rehire date is the employee's new open enrollment date. Otherwise, the rehired individual will be considered a new employee and must complete your company's new-hire eligibility waiting period.

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

Dependent eligibility

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

1. Spouses

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

2. Domestic partners

Blue Shield plans cover domestic partners under the same terms and conditions as spouses, and domestic partners follow the same enrollment procedures as spouses.

A domestic partner is an individual who is personally related to the Subscriber by a domestic partnership that meets the following requirements:

1. Both partners are 18 years of age or older, except as provided in Section 297.1 of the California Family Code.
2. The partners have chosen to share one another's lives in an intimate and committed relationship of mutual caring.
3. The partners are (a) not currently married to someone else or a member of another domestic partnership, and (b) not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited.
4. Both partners are capable of consenting to the domestic partnership; and
5. If required under your Employer's written policy, both partners must file a Declaration of Domestic Partnership with the California Secretary of State, pursuant to the California Family Code. The partners have filed a Declaration of Domestic Partnership with the Secretary of State. (Note, some Employers may permit partners who meet the above criteria but have not filed a Declaration of Domestic Partnership with the Secretary of State to be eligible for coverage as a Domestic Partner under the plan If permitted by your company, such individuals are included in the term "Domestic Partner" as used in the Evidence of Coverage; however, the partnership may not be recognized by the State for other purposes as the partners do not meet the definition of "Domestic Partner" established under Section 297 of the California Family Code). The domestic partnership is deemed created on the date when both partners meet the above requirements.

3. Dependent children

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

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

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

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

Dependent eligibility (cont'd)

4. Disabled over-age dependent children

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

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

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

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

In addition, the employee must submit a Declaration of Disability for Over-Age Dependent Children Form. If the disabled child is covered as a dependent under another carrier, the ENTS form from the other carrier will be required.

5. Qualified Medical Child Support Order (QMCSO)

A dependent child who is ordered to have coverage by the court is eligible even if they are:

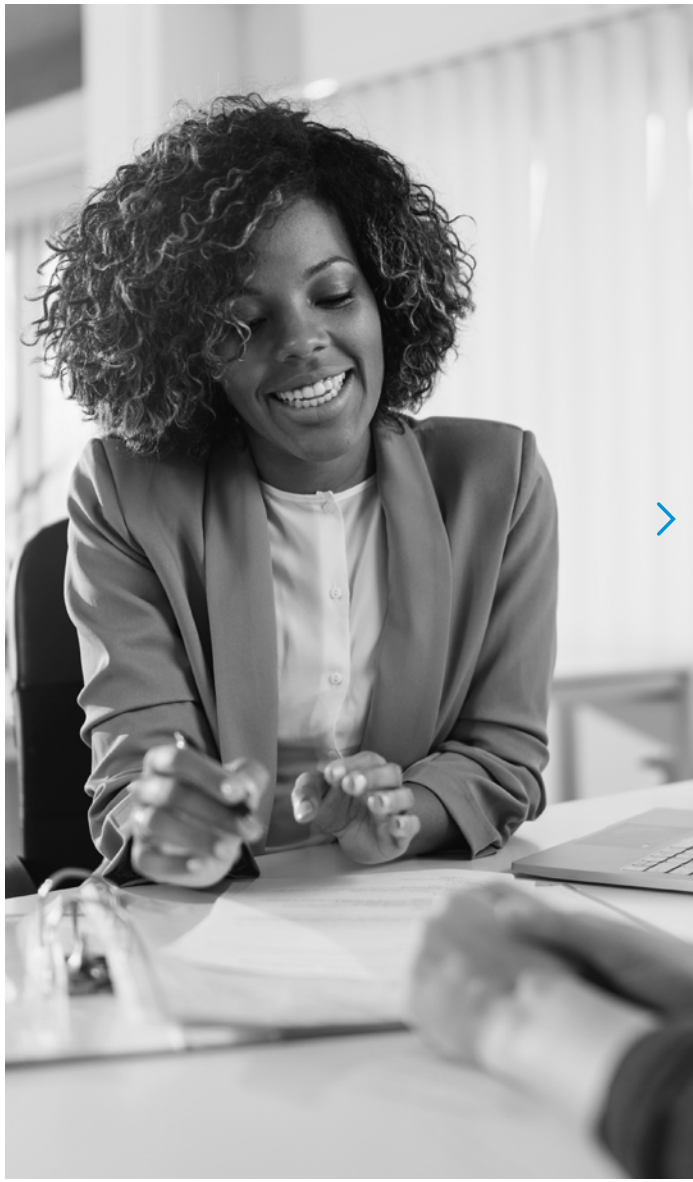
- Born out of wedlock; or
- Not claimed as a dependent on the parent's federal income tax return; or
- Not residing with the parent or within the Blue Shield HMO service area

(For additional information on out-of-service area coverage, see the "Away From Home Care program" section on page 28.)

If the parent fails to apply for coverage for a child, Blue Shield will enroll the child if a copy of the stamped and filed 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

If adding a dependent due to their loss of coverage with another carrier, the employer will need to submit proof of the qualifying event prior to the application being processed.



Ineligible individuals

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

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

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

Enrollment

Enrollment procedures

Annual open enrollment

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

During open enrollment:

- An employee who originally refused coverage can enroll
- An employee can add dependents that originally refused coverage
- Employees and their dependents may enroll 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)

This is also the time when you can:.

- Restructure the plan options you currently offer your employees
- Change waiting periods
- Change contribution levels/amounts
- Request to cover employees working at least 20 hours, but no more than 29 hours, per normal work week

Waiting periods

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

1. Effective first of month following date of hire (If hired on the first of month, coverage will be effective first of following month)
2. Effective first of month following 30 days from date of hire
3. Effective first of month following 60 days from date of hire
4. Effective on the 91st day following date of hire (a group may be partial-billed when electing the 91st day waiting period)

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

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

Initial enrollment for new employees

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

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

Adding dependents

To add a dependent, simply go to Employer Connection.

Please make sure that HMO plan applicants select a primary care physician (PCP) for each dependent.

To add a newborn child, you must complete the submission within 60 days from the child's date of birth. During the child's birth month, HMO plan members must select for the child a PCP who is with the same IPA or medical group as the mother's PCP (or father's PCP if the mother is not covered on the plan). After 60 days, the newborn child will be considered a late enrollee. (See page 16 for more information on late enrollment.)

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

During open enrollment:

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

Selecting a primary care physician (HMO plan only)

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

Your employee must select a primary care physician (PCP) who is located near their home or work address. Each of your employee's dependents must also choose their own PCP.

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

- Do not select a PCP when they enroll in an Access+ HMO,® Local Access+ HMO, or Trio HMO plan

Please note:

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

- Select a doctor who is not a participating physician in the Access+ HMO, Local Access+ HMO, or Trio HMO provider network
- Choose a specialist who is not also a PCP
- Select a doctor who is not accepting new patients, unless the employee is a current patient and checks the appropriate box on the Employee Application

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

Identifying plan-to-plan transfers

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

Late enrollment

Managing late enrollment

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

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

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

- Following the birth of a newborn, the adoption of a child, or a Qualified Medical Child Support Order (QMCSO)
- After marriage
- After the establishment of a domestic partnership
- Prorating of premium may apply
- After the loss of eligibility of other coverage

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

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

Exceptions to late enrollment

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

- Was covered under another group-sponsored health plan at the time they were eligible to enroll; and
- Certified on the "Refusal of Personal Coverage" section of the Employee Application during initial enrollment that they declined enrollment because they were covered under another group-sponsored health plan (Individual and Family Plans do not qualify as another group-sponsored health plan); and
- Lost or will lose coverage under their other group-sponsored health plan due to any of the following six situations:

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

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

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

Member ID cards

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

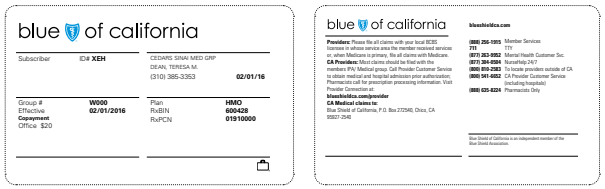
For additional cards, members can log in to blueshieldca.com and click on View/Print ID Card, or call the number listed on their Blue Shield medical ID card. If they have lost their card, they can log in to blueshieldca.com and click on View/Print ID Card or call customer service at (800) 218-8601.

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

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

Trio HMO ID card sample

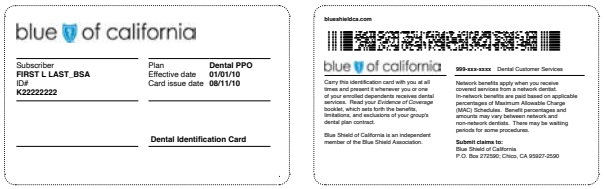
HMO ID card sample



PPO ID card sample

Dental HMO ID card sample

Dental PPO ID card sample



How to manage your group medical benefits

Employee status changes

Name and address changes

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

Leave of absence

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

If your company requires employees to pay for their group health plan coverage during the leave period, payment must be made payable to your company and not to Blue Shield. 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 allowable length of a leave of absence is determined by your company's personnel policy. Therefore, your company's policy determines when the employee on leave is terminated. When you terminate an employee, you must notify Blue Shield through Employer Connection at blueshieldca.com/employer. When an employee on leave is terminated, they may qualify for continuation coverage in the same manner as a terminated employee who was actively working on their last day of coverage.

Divorce or legal separation

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

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

For more information, see the "Coverage cancellation and options for employees" section starting on page 22.

Termination of domestic partnership

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

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

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

For ownership or group name change

Be sure to keep your Small Business information current, especially if you have a change of ownership or a name change. This would include the sale of your business that results in any of the following: new ownership, new business entity, merging with another business entity and becoming a subsidiary, sale of assets and liabilities of that entity, or a simple name change or sale of company stock. For any of these examples, please contact your broker or Blue Shield Group Services **(800-325-5166)** so they can walk you through a Name Change checklist over the phone quickly and easily. Once complete, your group information will be processed.

Claims process (for PPO plans only)

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

Participating providers

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

Non-participating providers

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

- Pay the bill; and then
- Mail the itemized bill, along with a Subscriber's Statement of Claim form, to Blue Shield at the address listed in the "Forms" section starting on page 50

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

Explanation of Benefits

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

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

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

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

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

Grievance process

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

Coverage cancellation and options for employees

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

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

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

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

Employee coverage changes and cancellation

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

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

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

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

Helpful hints:

- When an employee's coverage is cancelled, all covered dependents lose eligibility and their group coverage is cancelled automatically.
- If an employee voluntarily cancels their group coverage (when not terminating employment with your company), a Refusal of Coverage form must be submitted. If the employee later wishes to re-enroll, the employee must comply with the late enrollee guidelines, outlined on page 16, or wait until open enrollment. Please note that a Refusal of Coverage is not a COBRA or Cal-COBRA qualifying event. You do not need to submit anything to Cal-COBRA, but the group will need to submit the Refusal of Coverage form with a cancellation request in order to have the employee removed from billing.
- Employees must be a resident of California in order to be eligible for COBRA coverage if enrolled in an HMO plan. However, non-residents may be eligible to transfer to a PPO plan if you offer one. Please contact your Blue Shield Representative or Group Services **(800-325-5166)** about continuation coverage for your out-of-state employees.
- For Cal-COBRA groups (2 to 19 eligible employees), employers should complete the Employer Notification of Qualifying Events under Cal-COBRA form so the employee can be notified of their Cal-COBRA options.
- When a specialty product is sold with medical coverage, and the group elects to cancel its medical coverage, we will cancel only its medical coverage and maintain the dental, life,* or vision coverage unless specifically requested to cancel the specialty product.

Dependent coverage changes and cancellation

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

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

The pediatric and dental vision benefit for dependent children will be cancelled when they reach age 19; however, the specific cancellation date of coverage varies for pediatric dental and vision benefits.

- Pediatric dental coverage: Eligibility for the pediatric dental benefit ends on the last day of the month the dependent child turns age 19. For example, a dependent child who turns age 19 on April 15 will be eligible for dental benefits until April 30.

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

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

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

- A spouse who divorces or legally separates from a covered employee and becomes ineligible for group coverage.
- The subscriber's dependent children if the subscriber decides to cancel the dependent children from his or her coverage.
- When a domestic partnership terminates, group coverage of the employee's domestic partner and their 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 19.

Please note: Federal COBRA does not require continued coverage for domestic partners except when the employee elects COBRA and enrolls the domestic partner as a dependent.

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

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

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

Credit for prior coverage

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

State Cal-COBRA and federal COBRA continuation coverage

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

COBRA coverage

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

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

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

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

Cal-COBRA administration

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

Notice to Blue Shield of Cal-COBRA qualifying event

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

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

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

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

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

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

COBRA disability extension

A member may extend their 18-month COBRA 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 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 period. The member is responsible for notifying the employer or Blue Shield within 30 days of any final determination affecting their disability status.

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

Cal-COBRA coverage for COBRA enrollees

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

These conditions apply:

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

Cal-COBRA notification requirements for COBRA plan administrators

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

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

Coverage options for employees and retirees who have Medicare coverage

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

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

Employers with 20+ employees

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

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

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

Extension of benefits for disabled members

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

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

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

Transitioning to Medicare with Blue Shield

The closer your employees get to Medicare eligibility, the more we can help.

Transitioning to one of our Medicare coverage options can be fairly seamless if your employees are already valued members of Blue Shield. We understand how Medicare works and how your employees can get the most from it.

We'll guide them through the Medicare landscape, answer their questions, and remind them of deadlines. We can enroll them in a coverage option that helps pay for the things that Original Medicare by itself doesn't cover. For more information, your employees can call Blue Shield 65 Plus (HMO) Member Services at **(800) 776-4466** [TTY: **711**] 8 a.m. to 8 p.m. PT, seven days a week, from October 1 through March 31, and 8 a.m. to 8 p.m. PT, weekdays (8 a.m. to 5 p.m. Saturday and Sunday) from April 1 through September 30 to speak with one of our representatives, or visit blueshieldcamedicare.com.

Filing for an extension of benefits for disabled members

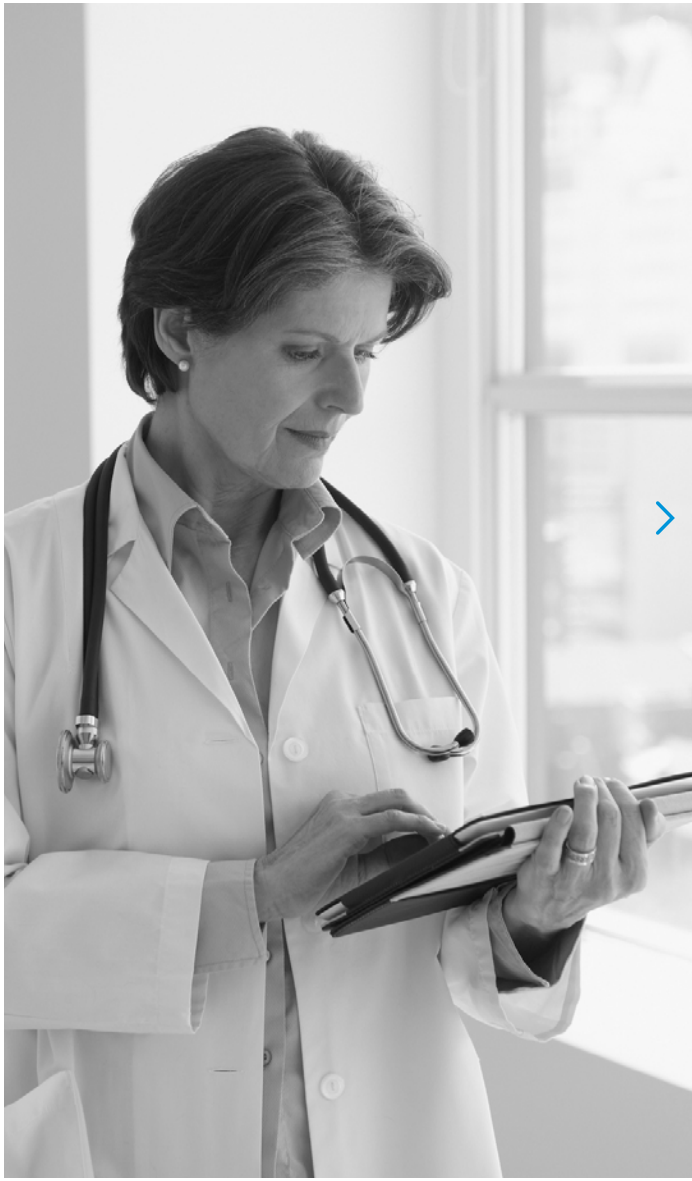
To file for an extension of benefits:

- The employee must complete a Subscriber Statement of Disability form, and
- Employer must complete a Notice of Total and Permanent Disability form and then mail both forms to the Program Management/Extension of Benefits address listed under the "Forms" section starting on page 50.
- The disabled member's primary care physician must submit an Attending Physician Statement of Disability form to Blue Shield at the address listed in the "Forms" section starting on page 50.

For additional coverage options for employees and dependents, please go to blueshieldca.com/employer, and click on Small Group Plans (1-100) under Medical Plans & Benefits. You can also contact your Blue Shield broker to learn about:

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

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



Access to care outside California

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

BlueCard Program

For Blue Shield HMO plan members

The BlueCard Program provides members and their covered dependents access to medically necessary urgent and emergency care throughout the United States.

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

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

For Blue Shield PPO plan members

BlueCard provides members, and their covered dependents, access to medical care throughout the United States. Your health plan's Evidence of Coverage or Certificate of Insurance describes member eligibility in the BlueCard Program. If your employees have questions about BlueCard, please refer them to their member guide for step-by-step instructions on how to use their BlueCard services.

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

Blue Shield Global Core program

For Blue Shield HMO plan members

The Blue Shield Global Core program provides members and their covered dependents access to medically necessary urgent and emergency care worldwide. If members need emergency care services, they should seek care at the nearest medical facility and appropriately use the 911 emergency response system when it is available. It's easy to find a BlueCard provider outside the U.S. You can locate one by visiting blueshieldca.com.

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

For Blue Shield PPO plan members

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

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

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

Away From Home Care program (for HMO plan members)

The Away From Home Care® program provides HMO and POS (point-of-service) plan members and their covered dependents access to care if they are:

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

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

Special arrangements may be available for:

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

Please note a few restrictions:

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

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

Members using the program's services outside California will receive the benefits offered in the service area they are visiting.

If you or your employees have questions about using these benefits, please contact Member Services to request an Away From Home Care program brochure.

HMO plan members must apply for Away From Home Care benefits. They can do so by calling the HMO Member Services number in the "Contact information" section on page 48.

Billing

Billing procedures

The following sections explain our billing procedures and requirements.

Paying your bill

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

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

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

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

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

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

Paying dues for new additions

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

Stopping payment for cancellations

If an employee is terminated during the month:

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

Delinquency

Here's what you need to know about our late payment policy and procedures:

- Blue Shield is a prepaid health plan. You will be billed prior to the payment due date.
- Group premiums are due on the due date printed on the Group Bill.
- If the group fails to make a premium payment by the due date, Blue Shield will send a Notice of Start of Grace Period to the group notifying them that past due payment has triggered a grace period starting from the day the notice is dated.

Notice of Start of Grace Period

We will issue a Notice of Start of Grace Period when we haven't received outstanding premium payment in full by the payment due date.

The Notice of Start of Grace Period contains:

- The start and end date of the 30-day grace period
- The date of cancellation if payment remains outstanding by the time the grace period ends
- A pre-addressed envelope for submitting the premium

If you submit the outstanding premium payment on time and receive the 30-day Grace Period Notice in error, please contact your group billing representative at **(800) 325-5166** or email small.group@blueshieldca.com.

Cancellation procedures

Requesting cancellation of your group account

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

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

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

Administrative cancellation

If your group no longer meets the eligibility requirements defined by state law (see the "Eligibility requirements" section starting on page 9), you will be notified prior to your renewal and given 30 days to respond to our request for documents confirming your group's continued eligibility for renewal. If your group is not compliant with eligibility requirements, your Small Business coverage will not be guaranteed renewable. If we do not receive requested information to confirm eligibility, your group may not be eligible for renewal.

Please note:

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

Nonpayment of premiums

We consider an account late when we do not receive the group premiums by the due date printed on the Group Bill.

Here is the procedure for late accounts:

- If you fail to make a premium payment by the due date, we will send you a Notice of Start of Grace Period that your past due premium payment has triggered a 30-day grace period starting from the day the notice is dated.
- The 30-day grace period may not begin sooner than the day after the last date of paid coverage, and we shall provide coverage based on the terms of your contract during the entire grace period.
- The group is financially responsible for any and all premiums and any copayments, coinsurance, or deductible amounts obligated under the plan contract, including those incurred for services received during the grace period.
- If we fail to receive all outstanding premium amounts from you on or before the last day of the grace period, as specified in the grace period notice, your coverage may be canceled only after the expiration of the entire grace period.
- We will send you a Notice of End of Coverage after the date coverage ends and no later than five (5) calendar days after the coverage ended.

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

How to manage your group dental benefits

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

Under the Affordable Care Act (ACA), pediatric dental coverage is an Essential Health Benefit (EHB). Note that all eligible dependent children to the age of 19 must have dental coverage as an embedded benefit of their medical plan; however, employees and dependents who are 19 to 26 years old will not receive pediatric dental coverage and, therefore, will not be required to pay any premiums. There is not a separate dental ID card for pediatric members covered under essential health benefits requirements; pediatric dental benefits are embedded in the medical plan and the medical ID card contains the pediatric dental information.

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

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

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

Enrolling employees and dependents

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

Employee status change

You are responsible for maintaining accurate eligible employee information.

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

Invoice procedures

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

Open enrollment

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

Dental HMO plan provider change

Dental HMO members may change their current dental provider at any time by calling Dental Member Services at **(888) 702-4171**. Changes are effective the 1st of the following month.

Nationwide PPO 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, INO, or HMO network by:

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

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

Submitting a claim

Dental HMO plan claims handling

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

Dental PPO plan claims handling

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

Dental INO* plan claims handling

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

Manage your dental members online

Manage your dental members easily online using Employer Connection. Forms for administering group dental benefits can be printed from blueshieldca.com/employer and clicking on the Forms link under "Reference Library." Or you can order forms by contacting your Blue Shield Representative.

Dental Member Services

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

Dental HMO, PPO, and INO: **(888) 702-4171**
5 a.m. to 8 p.m. PT, Monday through Friday

Grievance process

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

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

Blue Shield of California
Dental Appeals/Grievances
P.O. Box 30569
Salt Lake City, UT 84130-0569

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

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

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

How to manage your group vision benefits

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

Enrolling employees and dependents

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

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

Employee status change

You are responsible for maintaining accurate eligible employee information.

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

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

Invoice procedures

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

Open enrollment

Approximately 45 days prior to your group's renewal date (the anniversary date of the group's contract), you should schedule an open enrollment period to help your employees understand their benefits and options. For assistance in planning your group's open enrollment period, please contact your broker or Blue Shield 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/fad.
- For out-of-state providers, go to blueshieldcavision.com.

Vision plan information card

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


blue of california

Vision plan information card

Here's how to get vision services:

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

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

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

Here to help

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

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

MES Vision

Blue Shield of California, an independent member of the Blue Shield Association ABU15756-CA (4/16)

Submitting a claim

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

Mail completed claim form(s) and documentation to:

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

Manage your vision members online

Manage your vision members easily online using Employer Connection. Forms for administering group vision benefits can be printed from blueshieldca.com/employer and clicking on the Forms link under "Reference Library." Or you can order forms by contacting your Blue Shield Representative.

Vision Member Services

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

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

Grievance process

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

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

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

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

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

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

How to manage your group life insurance benefits

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

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

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

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

Enrolling employees and dependents

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

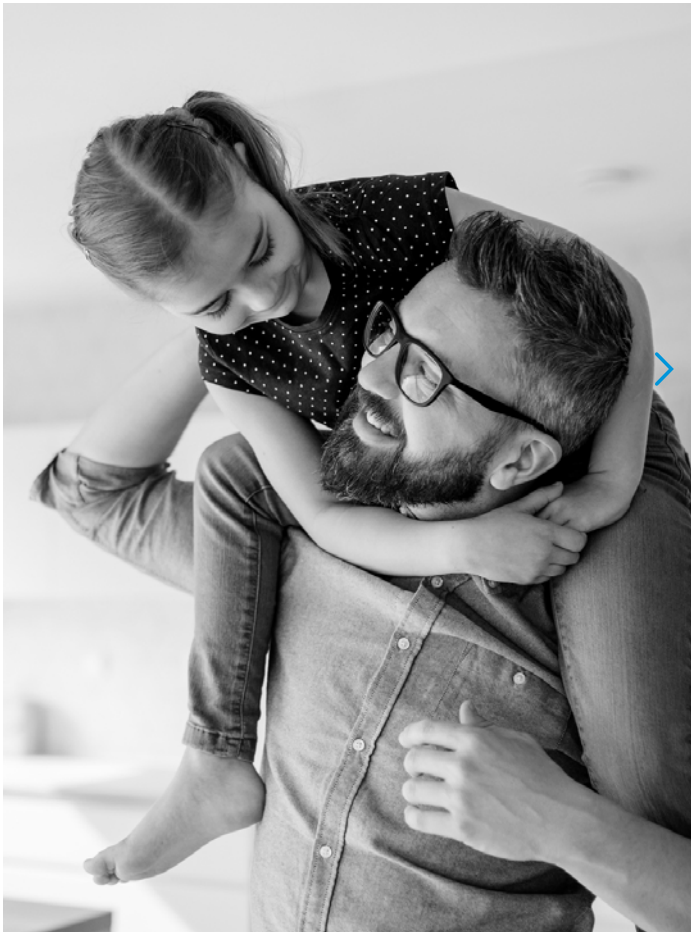
For contributory groups, employees who did not apply for coverage when they were first eligible or at the time of a qualifying event (birth, death, divorce, etc.) will be required to submit an Evidence of Insurability form (CP1021) and may be subject to medical underwriting in order to obtain coverage.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

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

Employee status change

You are responsible for maintaining accurate eligible employee information.

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



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

Counseling employees on naming beneficiaries

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

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

Invoice procedures

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

Certificate of Insurance

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

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

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

The following documents are required for a life insurance claim:

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

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

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

The following documents are required for a dismemberment claim:

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

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

Mail claim form and documentation to:

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

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

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

How to submit a Waiver of Premium claim

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

The following documents are required:

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

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

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

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

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

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

Mail Waiver of Premium claim form and documentation to:

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

* 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.

How to submit an accelerated death benefit (ADB) claim

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

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

The following documents are required:

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

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

Mail ADB claim form and documentation to:

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

How to convert from term life insurance to whole life insurance

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

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

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

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

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

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

Applicants should complete and submit an Individual Conversion Life Insurance Policy application form (CP1020) within 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. Paycheck stubs showing the number of hours the employee worked for the two months prior to the last day the employee reported to work will also be required.

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

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

* 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.

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

Mail the Individual Conversion Life Insurance Policy application form to:

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

Forms

Forms for administering group life insurance are listed on page 51. You can print them from blueshieldca.com/employer and clicking on the Forms link under "Reference Library." Or you can order forms by contacting your Blue Shield Representative.

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

Grievance process

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

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

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

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

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

Important information

Contact information

For benefit administrators

Topic	Contact information
Group eligibility and online support	Group Employer Services Department (800) 325-5166 Email: small.group@blueshieldca.com
Billing inquiries	Blue Shield Small Business Billing Services Email: smallgroupbilling@blueshieldca.com (800) 325-5166
Cal-COBRA eligibility, coverage, extensions and cancellations	Blue Shield of California Cal-COBRA Administration P.O. Box 629009 El Dorado Hills, CA 95762-9009 (800) 228-9476 Fax: (916) 350-7480
Questions about group services for federal COBRA	(800) 325-5166
Questions about employer-administered flexible spending account (FSA) programs	HealthEquity (877) 857-6810
For ownership or group name change	Please contact your broker or Blue Shield Group Services at (800) 325-5166 and request a Group Change Request form.

For your employees

Reason	Contact information
Member assistance for benefits, claims, and service providers	Blue Shield HMO Member Services at the number listed on the Blue Shield member ID card
Member assistance for Trio HMO benefits and services	Shield Concierge at (855) 664-5577 or the number listed on the Blue Shield member ID card
Member assistance for Tandem PPO benefits and services	Shield Concierge at (877) 806-7589 or the number listed on the Blue Shield member ID card
Group term life insurance and accidental death and dismemberment claims inquiries	Blue Shield Life insurance claims (888) 800-2742
Member assistance for Blue Shield dental benefits and services	Dental Member Services (888) 702-4171 5 a.m. to 8 p.m. Pacific time, Monday through Friday
Member assistance for Blue Shield vision benefits and services	Vision Member Services (877) 601-9083 8 a.m. to 5 p.m. Pacific time, Monday through Friday
Cal-COBRA	(800) 228-9476
Questions about chiropractic and acupuncture benefits	American Specialty Health Plans (ASH) benefits and services for HMO and PPO members: (800) 678-9133
Claims process and benefit information for mental health benefits and substance use disorder treatments	Blue Shield's mental health service administrator (MHSA) HMO and PPO members: (877) 263-9952 Claims: (877) 263-9952
To order mail service prescriptions	Mail service pharmacy: (866) 346-7200 TTY: 711 Caremark.com
Pharmacy Services	Questions and information on drugs requiring prior authorization or step therapy. Call the number listed on the Blue Shield ID card
Member assistance for Blue Shield 65 Plus℠ (HMO) benefits and services	Blue Shield 65 Plus (HMO) Customer Care (800) 776-4466 TTY: 711 8 a.m. to 8 p.m. Pacific time, seven days a week from October 1 through March 31, and 8 a.m. to 8 p.m. Pacific time, weekdays (8 a.m. to 5 p.m., Saturday and Sunday) from April 1 through September 30
Member assistance for Blue Shield Medicare Rx benefits and services	Blue Shield of California Medicare Rx Plan (PDP) Customer Care (888) 239-6469 TTY: 711 8 a.m. to 8 p.m. Pacific time, seven days a week from October 1 through March 31, and 8 a.m. to 8 p.m. Pacific time, weekdays (8 a.m. to 5 p.m., Saturday and Sunday) from April 1 through September 30
No-cost language services for members to reach an interpreter or have documents read aloud or sent in the mail	Language-assistance services to people whose primary language is not English such as qualified interpreters and information written in other languages Call the phone number on the Blue Shield member ID card or (866) 346-7198
Provides aids and services at no cost to people with disabilities to communicate effectively with us	Qualified sign language interpreters Written information in other formats (including large print, audio, accessible electronic formats, and other formats)

Appendix


My plan
My plan
PLAN DETAILS
plan info, balances, usage, and more
ID CARDS
your insurance card at your fingertips
CLAIMS
check your claim status
BENEFITS
get the most from your plan
PLAN MEMBERS
manage family access
PHARMACY
prescription drug resources

Forms

To get copies of any of the following forms, go to blueshieldca.com/employer and click on Forms under "Reference Library." If you need additional assistance, contact your broker or Blue Shield Representative.

Employer forms

Master Group Application (form C15385)	If you currently offer dental plans, and/or vision plans, and/or basic life and AD&D insurance only, and are purchasing medical plans, please use this Master Group Application.
Employer Notification of Qualifying Event Under Cal-COBRA (form C13140)	Cal-COBRA is for employers with 2 to 19 employees and is administered by Blue Shield. Use this form to give written notification to Blue Shield of a subscriber's termination or reduction of hours, within 30 days of the event.
Group Change Request (form A52260)	Use this form to submit open enrollment changes during the renewal period, including adding dental or vision plans and basic life and AD&D insurance. If you currently offer dental plans, and/or vision plans, and/or basic life and AD&D insurance only, and are purchasing medical plans, please use a Master Group Application rather than a Group Change Request.
Employee Cancellation Notification (form A36965)	As a group contact, complete this form to submit information on employee terminations/ cancellations.
Group Information Update (form A44464)	Use this form to update a billing address or contact information.
Notice of Total and Permanent Disability (form C4424)	To file for an extension of benefits in the case of a total and permanent disability, you need to complete this form. In addition, employees must complete a Subscriber Statement of Disability.

Employee forms

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

Employee forms (con't)

Continuing Cal-COBRA under Blue Shield of California **Cal-COBRA Take-Over (form C14755)**	Employees should complete these forms to elect Blue Shield of California over Cal-COBRA coverage from a prior carrier. To get additional copies of forms for your employees, go to blueshieldca.com/employer and click on Employee Forms. You can then view, download, and print any form.
Cal-COBRA form (C18157)	For employees who have exhausted coverage under federal COBRA and were not entitled to the maximum period or have been covered as a domestic partner and the partnership terminated.
Subscriber's Statement of Claim (form CLM-14850)	Employees should use this form when the provider of service does not submit its claims directly to Blue Shield. Employees must attach a copy of their itemized bill (which should be on the provider's letterhead or billing form) to this completed form, and send them to the service center address listed. Employees should complete this form only when the providers of service do not submit their claims directly to Blue Shield. This is for Blue Shield of California plans only.
Subscriber's Statement of Claim Blue Shield Life (form CLM-15481)	Employees should use this form when the provider of service does not submit its claims directly to Blue Shield of California Life & Health Insurance Company (Blue Shield Life). Employees must attach a copy of their itemized bill (which should be on the provider's letterhead or billing form) to this completed form, and send them to the service center address listed. Employees should complete this form only when the providers of service do not submit their claims directly to Blue Shield Life. This is for Blue Shield Life plans only.
Declaration of Disability for Over-Age Dependent Children (form C3674)	Employees should fill out this form to enroll a dependent who would normally have lost their eligibility solely due to age but who is disabled by reason of a physically or mentally disabling injury, illness, or condition.
Attending Physician Statement of Disability (form C4425)	To file for an extension of disability benefits, the employee's primary care physician must complete and submit this form to Blue Shield. In addition, employees must complete a Subscriber Statement of Disability form and you must fill out a Notice of Total and Permanent Disability form.
Subscriber Statement of Disability (form C12198)	To file for an extension of disability benefits, employees must complete this form. In addition, you need to complete a Notice of Total and Permanent Disability.
Authorization to Disclose Personal & Health Information to a Third Party (form A46163)	Blue Shield requires specific written authorization for the disclosure of any personal and health information, beyond that which is necessary to provide treatment, to facilitate payment, or to perform operations of the health plan or insurer, to the extent permitted by law. Blue Shield will only disclose that information which is reasonably necessary to achieve the purpose of the request for release.
Dental Claim Form (form C11716)	Employees should complete this form to submit a dental claim for services received from a non-network provider.
Vision Claim Form (form C-4669-61)	Employees should complete this direct reimbursement form for vision care services received from a non-network provider.
Vision Plan Information Card ABU15756-CA (for California members) ABU15756-OOS (for members outside California)	The card is not required, but has useful information for both the member and the provider.
Life insurance forms	Forms for administering group life insurance and/or AD&D insurance benefits are listed below. They can be easily downloaded and printed from blueshieldca.com, or ordered by contacting your Blue Shield Representative.
Accelerated Death Benefit Claim (form ABU1139)	Employer, employee, and/or attending physician will need to complete this form for insured persons to receive life benefit proceeds prior to their death. See plan benefits for eligibility provisions.
Life and AD&D Waiver of Premium Claim (form ABU1182)	Employer, employee, and/or attending physician will need to complete this form for insured employees who become totally disabled* before age 60 to continue their life coverage at no cost (i.e., waiving the premium). See plan benefits for eligibility provisions.
Life Insurance Proof of Death Claim (form ABU1180)	Employers should complete this form in the event an employee passes and submit it with the other required documents.
Conversion to Individual Policy from Group Life Insurance (form CP1020)	Employer and employee should complete this form when an employee loses their group term life coverage and they wish to convert it to individual whole life.
Life and AD&D Statement of Domestic Partnership (form C15388)	Employees should complete this form when they have additions, deletions, and other changes to their coverage.
Life and AD&D Beneficiary Change Request (form ABU1165)	Employees should complete this form when they have additions, deletions, and other changes to their coverage.

* 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.

Where to send completed employer forms

Form name	Form number	Where to mail form	Where to fax form
Request for Contract Change	C15782	Membership Eligibility Processing Unit Blue Shield of California P.O. Box 3008 Lodi, CA 95241-1912	(855) 808-8598 or email small.group@blueshieldca.com
Master Group Application	C15385	Membership Eligibility Processing Unit Blue Shield of California P.O. Box 3008 Lodi, CA 95241-1912	(209) 367-6475 or email small.group@blueshieldca.com
Employee Change Transmittal	C3843	Membership Eligibility Processing Unit Blue Shield of California P.O. Box 3008 Lodi, CA 95241-1912	(855) 808-8598 or email small.group@blueshieldca.com
Employer Notification of Qualifying Events Under Cal-COBRA	C13140	Blue Shield of California Cal-COBRA Administration P.O. Box 629009 El Dorado Hills, CA 95762-9009	(916) 350-7480
Continuing Group Coverage after Federal COBRA Cal-COBRA Election	C18157	Blue Shield of California Cal-COBRA Administration P.O. Box 629009 El Dorado Hills, CA 95762-9009	(916) 350-7480
Notice of Total and Permanent Disability	C4424	Blue Shield of California Program Management Office/Extension of Benefits 4203 Town Center Blvd. El Dorado Hills, CA 95762-9806	(855) 808-8598
Group Information Update	A44464	Membership Eligibility Processing Unit Blue Shield of California P.O. Box 3008 Lodi, CA 95241-1912	(855) 808-8598 or email small.group@blueshieldca.com

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

Where to send completed employee forms

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

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