

# group administrator guide

.....  
for small businesses with 2 to 50 eligible employees  
.....

# Welcome to Blue Shield

Thank you for choosing Blue Shield as your health plan. We are pleased to have you and your employees as part of the Blue Shield family. As a benefits administrator, you play many important roles in your group's health coverage, especially given changes in the healthcare environment, and we are here to support you every step of the way.

Now more than ever, we're committed to you and want to make the administration of your plan benefits as easy as possible, for you and your employees. From customer service to claims to online resources, we take the trust you've placed in us very seriously and always strive to provide world-class service.

In this guide, you'll find simple, step-by-step instructions for eligibility, enrollment, payment, and many other processes. Easy-to-use reference charts will guide you to the right person, so you can get quick answers to your administrative questions. We've also dedicated a section to forms, so you'll know at a glance what needs to be filled out, when, and where to send it.

In addition, we offer you a wealth of information and resources online. Simply log onto Employer Connection at [blueshieldca.com/employer](https://blueshieldca.com/employer) to find a wide variety of online services that will help make the administrative process easier for you. And if you don't find the answers to your questions either in this guide or online, your Blue Shield representative and Account Manager are here to help. They are just a phone call away.

As we learn more and begin to implement the health reform changes, you can access our most up-to-date information at [blueshieldca.com/employer-health-reform](https://blueshieldca.com/employer-health-reform) or visit the Department of Health and Human Services health reform site at [healthcare.gov](https://healthcare.gov).

We value your business and look forward to a long and healthy relationship. You and your employees deserve our very best and we appreciate the chance to serve you.

Again, thank you for choosing Blue Shield.

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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# Contact information

## for benefits administrators

Topic	Contact information
Group eligibility	Group Employer Services Department <b>(800) 325-5166</b>
Billing issues or for changes to your account	Blue Shield of California Small Group Billing Services <b>(209) 371-3484</b>
Cal-COBRA eligibility, coverage, extensions, and cancellations	Blue Shield of California Cal-COBRA Administration P.O. Box 629009, El Dorado Hills, CA 95762-9009 <b>(800) 228-9476</b> Fax: <b>(916) 350-7480</b>
Questions about Employer-Administered Flexible Spending Account (FSA) programs	Contact your Blue Shield Account Manager or Ceridian Benefits Services at <b>(800) 767-4969</b>
For ownership or group name change	Please contact your broker or Blue Shield small-group Account Manager

## for your employees

Reason	Contact information
Member assistance for Blue Shield HMO or POS benefits and services	Blue Shield of California HMO and POS member services at <b>(800) 424-6521</b> , or call the number listed on their Blue Shield member ID card
Member assistance for Blue Shield PPO benefits and services	Blue Shield of California PPO member services at <b>(800) 200-3242</b> , or call the number listed on their Blue Shield member ID card
Member assistance for Blue Shield Life PPO benefits and services	Blue Shield Life PPO member services at <b>(888) 852-5345</b> , or call the number listed on their Blue Shield member ID card
Group term life insurance and accidental death and dismemberment claims inquiries	Blue Shield Life Insurance claims <b>(888) 800-2742</b> , option 3
Member assistance for Blue Shield HMO dental benefits and services	Dental HMO member services at <b>(800) 585-8111</b> 5:30 a.m. to 5 p.m., Monday through Friday
Member assistance for Blue Shield PPO dental benefits and services	Dental PPO member services at <b>(888) 702-4171</b> 5:30 a.m. to 5 p.m., Monday through Friday
Member assistance for dental benefits and services	Dental members of national accounts at <b>(800) 241-4896</b> 8 a.m. to 4 p.m., Monday through Friday

## for your employees (continued)

Reason	Contact information
Blue Shield vision benefits and services	Vision Member Services at <b>(877) 601-9083</b> ; 8 a.m. to 5 p.m., Monday through Friday
Questions about chiropractic and acupuncture benefits and services	American Specialty Health Plans (ASH Plans) for HMO and POS members, <b>(800) 678-9133</b>
Claims process and benefit information	Benefits, medical bills, and claims, <b>(800) 443-5005</b> TTY: <b>(800) 241-1823</b> Blue Shield of California P.O. Box 272580, Chico, CA 95927-2580
Claims process and benefit information for substance abuse treatments, mental health benefits, and to get information about filing a claim	Mental health services administrator (MHSA) For HMO, POS, and PPO members, call <b>(877) 263-9952</b> For Blue Shield Life members, call <b>(877) 214-2928</b> For claims, call <b>(877) 263-9952</b>
Questions about any pharmacy related issues	Pharmacy relations/prior-authorization at <b>(800) 443-5005</b> TTY: <b>(800) 241-1823</b>
To order mail-service prescriptions	Mail-service pharmacy at <b>(866) 346-7200</b> TTY: <b>(866) 346-7197</b>
Member assistance for Blue Shield 65 Plus HMO benefits and services	Blue Shield of California Medicare HMO Blue Shield 65 Plus HMO member services <b>(800) 776-4466</b> TTY: <b>(800) 794-1099</b> Blue Shield 65 Plus P.O. Box 927, Woodland Hills, CA 91367
Member assistance for Blue Shield Medicare Rx benefits and services	Blue Shield of California Medicare PDP Blue Shield of California Medicare Rx (PDP) member services <b>(888) 239-6469</b> TTY: <b>(888) 239-6482</b> Blue Shield Medicare Rx P.O. Box 927, Woodland Hills, CA 91367
Member service information	Bilingual and hearing-impaired services; bilingual customers should call the number listed on their Blue Shield ID cards or <b>(800) 248-5451</b> From Mexico <b>(001) 800-248-5451</b> TTY: <b>(800) 241-1823</b>
No-cost language services for members to reach an interpreter, have documents read aloud, or sent in the mail.	Language assistance services Call the phone number on the member ID Card or <b>(866) 346-7198</b>

# Online resources

## For benefit administrators

We strive to provide you with the information you need to simplify managing your group benefits. With a click of your mouse, you'll find time- and money-saving tools that will help make benefit administration easier. Just go to Employer Connection at [blueshieldca.com/employer](http://blueshieldca.com/employer) any time to find information about:

- Applications and forms
- Our health plans and provider networks
- Health reform changes
- Health & Wellness programs
- The latest Blue Shield news, and more

You can also access these time-saving online resources:

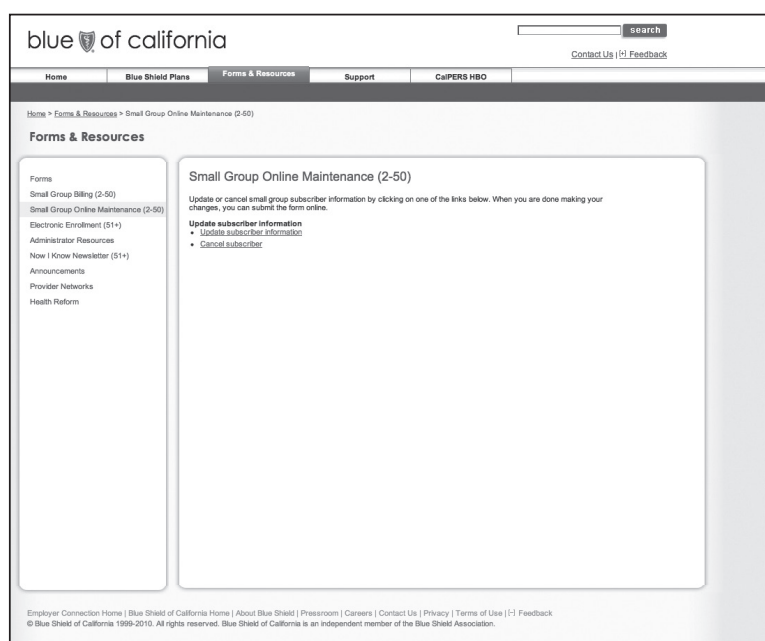
### Easy\$Pay online

Our Easy\$Pay<sup>SM</sup> Online payment tool helps you spend less time paying your bills and more time growing your business. With Easy\$Pay, you no longer have to be concerned about the hassle of writing and signing checks, making sure it's mailed on time because it's fast, convenient, and free!

You can:

- Automatically pay your bills with a click of your mouse
- Set up one-time or recurring monthly payments
- Conveniently track your payment status and view up to 12 months of payment history – all in one convenient location

For detailed information on Easy\$Pay, please see page 36.



## Online subscriber change request and cancellation

Quickly and easily update or delete a subscriber in your group from your computer by using our simple online tool. Just log in to [blueshieldca.com/employer](http://blueshieldca.com/employer) *Small Group Online Maintenance*, then choose either to update or cancel the subscriber, and fill out all the required fields. After submitting the information, you'll be prompted to a confirmation screen that lets you know your request was successful. It's that easy.

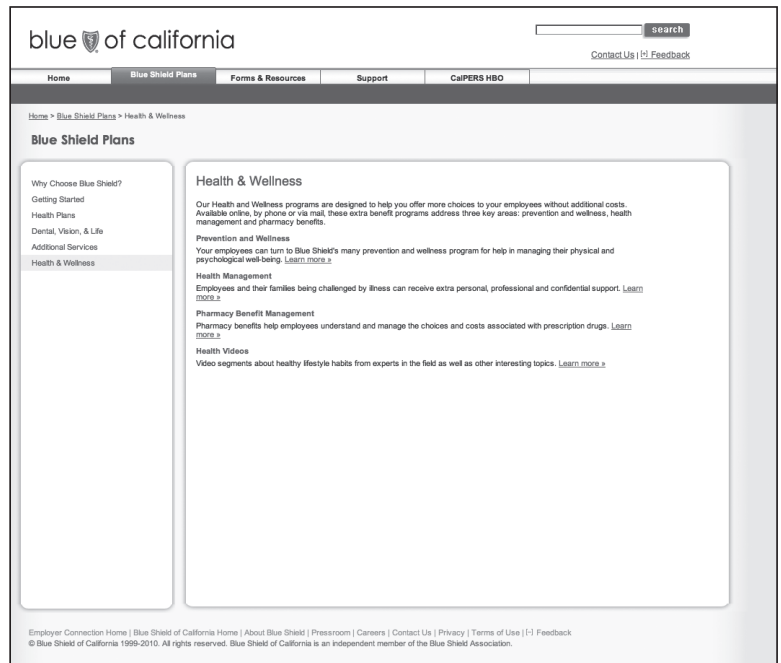
# How to navigate Employer Connection

Whether you want to download a claim form or learn about our wellness management programs, Employer Connection offers you easy, 24-hour access to the information you and your employees need to make the most of your healthcare coverage.

Finding information is simple. Just go to [blueshieldca.com/employer](http://blueshieldca.com/employer) to learn more about our provider network, download forms, or get information on wellness and other programs available for your employees.

## TIP!

This handy "How to Navigate Employer Connection" tear-away sheet makes it easy for you to use Employer Connection. Take advantage of the value-added health and wellness programs we offer you and your employees by finding out more online today.



## Here's a quick guide to some of the most useful resources Employer Connection offers:

- **Blue Shield plans** – Get updated plan information and benefit overviews for our health, dental, vision, and life plans. Find out about other add-on services. You can also learn about Flexible Spending Accounts (FSAs).
- **Health reform** – Understand what new health reforms are affecting you and your employees.
- **Find forms** – Download and print the forms you'll need, for everything from enrollment to claims.
- **Administrator resources** – Find updated information on what you need to know in managing your group benefits, including eligibility requirements to billing procedures.
- **Employer news and announcements** – Keep up to date on new products, benefit changes, and see the latest news on Blue Shield.
- **Provider network** – Find a provider, and learn about our extensive provider networks.
- **Health and Wellness programs** – Learn about our wide range of health and wellness programs for everything from surgical recovery to legal counseling at no additional cost to prenatal advice.

We regularly update Employer Connection to help you more easily manage your group's benefits. Visit [blueshieldca.com/employer](http://blueshieldca.com/employer) frequently to find the most up-to-date information.



## For employees

When employees come to you with questions about their health coverage, you can refer them to log in to [blueshieldca.com](https://blueshieldca.com) to view their confidential health plan information. Online registration for our website is simple and secure – employees just have to choose a user name and password, and their personal information will be encrypted to ensure their privacy.

### Once employees log in, they can:

#### Choose My Health Plan to:

- See highlights and details of their health, dental, or vision plan coverage
- Learn about their copayment and deductible amounts
- Check the status of their claims
- Print temporary Blue Shield ID cards

#### Choose Find a Provider:

- Search for a doctor, Independent Physician's Association (IPA) or medical group, hospital, urgent care center, dentist, pharmacy, or vision care or alternative care practitioner
- Print a personalized provider directory

#### Select Find a Provider Performance Profile to:

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

#### Select Health & Wellness to:

- Learn about our health management programs and apply online for some programs
- Participate in our online Healthy Lifestyle Rewards program and create a confidential health and fitness plan that's tailored to their individual needs
- Learn how to contact and use our LifeReferrals 24/7<sup>SM</sup> program

- Learn how to talk with a nurse by phone or online through our NurseHelp 24/7<sup>SM</sup> program
- Use our health encyclopedia to research a condition or treatment
- Sign up for our monthly *Health Update* e-mail newsletter filled with timely health and benefits information

#### Choose Pharmacy to:

- Search for a list of formulary drugs or generic alternatives, check formulary status of a drug, and view their copayment using the Drug Database and Formulary tool
- Check for drug interactions among prescription drugs, over-the-counter medications, dietary supplements, and herbal products using our Drug Interaction Checker.
- Search among our network of more than 5,500 retail pharmacies in California, two specialty pharmacies, and one mail-service pharmacy. Use *Find A Pharmacy* to locate the closest one that is open 24 hours.
- Order up to a 90-day supply of covered maintenance medications online through our contracted mail-service vendor, PrimeMail, and have them delivered directly to their home or office.
- Submit a confidential drug-related question using *Ask the Pharmacist* and receive a private response from a University of California, San Francisco pharmacist within two business days.

# Health & Wellness programs

Blue Shield has a wide range of programs to help members take control of their health and get the most value out of their healthcare coverage. Requiring no administration on your part and available at no extra cost to you or your employees, these valuable resources can really enhance your group's healthcare coverage. Please encourage your employees to use them!

## resource

## contact

### NurseHelp 24/7<sup>SM</sup>

This nurse support service offers your employees access to registered nurses who can provide immediate answers to medical questions and reliable information about health conditions.

### Call (877) 304-0504

Or log in to [blueshieldca.com](http://blueshieldca.com) and click on *Health & Wellness*, then *NurseHelp 24/7*.

### LifeReferrals 24/7<sup>SM</sup>

This program offers your employees personal counseling and work/life resource services. A team of experienced professionals can assist on a wide variety of topics such as personal issues, legal or financial questions, child/elder care, and chronic-condition management.

### Call (800) 985-2405

24 hours a day, seven days a week. Or log in to [blueshieldca.com](http://blueshieldca.com) and click *Health & Wellness*, then *LifeReferrals 24/7*.

### Healthy Lifestyle Rewards

We offer an interactive online program that helps motivate and support members in reducing modifiable risk factors and changing their behavior in key areas, such as fitness, nutrition, stress management, smoking cessation, and emotional wellness. Members can take a wellness assessment and be directed to recommended programs.

Log in to [blueshieldca.com](http://blueshieldca.com) and click on *Health & Wellness*.

### Decision support tools

When employees are faced with an important medical decision, this online resource helps them determine the care that's right for them. Our decision support tools provide members with access to personalized health reports, hospital comparisons, and pharmacy information.

For more information log in to [blueshieldca.com](http://blueshieldca.com) and click on *Health & Wellness*, then click on *Tools*.

### Condition management programs

These programs help your employees manage chronic conditions that can significantly impact their physical and emotional health, such as diabetes, asthma, chronic obstructive pulmonary disease (COPD), coronary artery (CAD) disease, and heart failure. They offer up-to-date health and wellness information and strategies for self-management, at no extra charge. In addition, we also offer a Prenatal Education Program, which includes a book as well as other helpful information on prenatal, and postpartum care.

### Call (866)-954-4567.

For Prenatal Education Program, call **(877) 371-1511**

Or, log in to [blueshieldca.com](http://blueshieldca.com) and click on *Health & Wellness*, then click on *Condition Management*. For the Prenatal Education Program, click on *Women's Health*.

### Wellness discount programs

Your employees' wellness is always important to us. So we offer a wide range of member discount programs\* that can help them save money and get healthier. These include Weight Watchers, 24 Hour Fitness, ClubSport and Renaissance ClubSport, drugstore.com, Mylifepath<sup>SM</sup> Alternative Care discounts, Vision Discount Program, and LASIK discounts. Employees can receive 20% off the published retail prices when they use a provider in the Discount Vision Program network for routine eye examinations, frames and lenses, photochromic lenses, tints and coatings, an extra pair of glasses, and non-prescription sunglasses.

For more information and to see a list of wellness discount vendors, members can log in to [blueshieldca.com](http://blueshieldca.com) and select *Health & Wellness*, then click on *Professional Help and Wellness Discount Programs*.

For information on vision network providers, members can log in to [blueshieldca.com](http://blueshieldca.com), and click on *Find a Provider*, then *Find a Vision Care Provider*.

\* The network of practitioners and facilities in the discount programs are managed by the external program administrators identified on the right, including any screening and credentialing of providers. Blue Shield does not review the services provided by discount program providers for medical necessity or efficacy. Nor does Blue Shield make any recommendations, representations, claims, or guarantees regarding the practitioners, their availability, fees, services, or products.

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

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

Discount programs administered by or arranged through independent companies:

- Mylifepath<sup>SM</sup> Alternative Care Discounts – Healthyroads Inc. (Healthyroads and American Specialty Health Networks are subsidiaries of American Specialty Health Incorporated).
- Discount Vision Program – MESVision
- LASIK and PRK – Laser Eye Care of California LLC
- Weight control – Weight Watchers North America
- Fitness facilities – 24 Hour Fitness, ClubSport and Renaissance ClubSport
- Health products (excluding prescription drugs) – drugstore.com inc.

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

# Assisting your employees

## Eligibility requirements

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

### Eligible employees

Use the four employee categories described below to help determine whether or not an employee is eligible for group coverage.

#### Full-time employees

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

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

Please note: Spouses/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.

#### Part-time and temporary employees

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

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.

#### Sole owners or partners of a partnership

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

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

#### Rehired employees

A former employee who is rehired is eligible for coverage on the first billing date after the rehire date if the individual meets one of the conditions below. He or she:

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

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

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

## Dependent eligibility

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

### Spouses

An employee's legally married spouse is eligible for dependent coverage if he or she is not legally separated from the employee. Same-gender marriages performed between June 16, 2008, and November 3, 2008, are lawful in California. Blue Shield treats same-gender spouses exactly the same as opposite-gender spouses.

### Domestic partners

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

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

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

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

### Dependent children

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

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

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

### Disabled over-age dependent children

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

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

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

- Within 31 days of the date the dependent child reaches the age eligibility would otherwise cease.
- And 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 (see page 46).

### Qualified Medical Child Support Order (QMCSO)

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

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

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

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

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

Enrollment paperwork for court-ordered dependent children must be submitted as soon as possible. Include a copy of the employees' Subscriber Change Request form (see page 45) and a copy of their court orders.

## Access to care outside of California

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

### BlueCard Program

#### For Blue Shield HMO and POS members

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

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

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

#### For Blue Shield PPO and Active Choice™ members

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

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

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

The BlueCard Program provides members and their covered dependents with worldwide access to care!  
Please visit [blueshieldca.com/employer/blue-shield-plans/out-of-area-coverage.jhtml](https://blueshieldca.com/employer/blue-shield-plans/out-of-area-coverage.jhtml)

## Away From Home Care program (for HMO members)

The Away From Home Care\* (AFHC) program provides Access+ HMO\* members and their covered dependents access to care if they are:

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

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

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

### Please note a few restrictions:

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

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

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

If you or your employees have questions about using AFHC benefits, please contact Member Services to request an AFHC program brochure. HMO members can also find this brochure at [blueshieldca.com](http://blueshieldca.com), by clicking on the *My Health Plan* tab and then clicking *Resources*.

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

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## 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, their spouses, or domestic partners
- Dependents living and working outside of a Blue Shield HMO service area who do not meet the AFHC program requirements
- Students living and attending school outside of Blue Shield's HMO service area who do not meet AFHC program requirements
- Foster children and grandchildren who are not legally adopted or for whom legal guardianship has not been established

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### TIP!

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

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# Eligibility requirements at a glance

## type of enrollee requirements

<b>Employee: permanent, year-round, full-time</b>	<ul style="list-style-type: none"> <li>• Works at least 30 hours per week</li> <li>• Performs job duties at your company's usual place of business</li> </ul>
<b>Employee: part-time</b>	<ul style="list-style-type: none"> <li>• Works 20 to 30 hours per week</li> </ul> <p>(Small-group employers with fewer than 50 eligible employees have the option to offer coverage to part-time employees)</p>
<b>Employee: temporary</b>	Not eligible for Blue Shield group coverage
<b>Sole owner or partner of a partnership</b>	<ul style="list-style-type: none"> <li>• Full-time employee and works at least 30 hours per week</li> <li>• Performs job duties at your company's usual place of business</li> <li>• Qualifies as an employee under your company's Blue Shield group health service contract</li> </ul>
<b>Spouse</b>	Legally married spouse who is not legally separated from the employee
<b>Domestic partner</b>	<ul style="list-style-type: none"> <li>• Domestic partner who is not terminated from the domestic partnership</li> <li>• Domestic partners are covered under the same terms and conditions as spouses</li> </ul>
<b>Dependent children</b>	Child of an employee (or employee's spouse or domestic partner) by birth, legal adoption, placement for adoption, or legal guardianship who is younger than 26 years of age, regardless of marital status, or residential status
<b>Disabled over-age dependent children</b>	<p>If a disabled child who is covered under a Blue Shield plan reaches the maximum age limit, coverage may continue if the child meets both of the following criteria. He or she is:</p> <ul style="list-style-type: none"> <li>• Incapable of self-sustaining employment because of a mentally or physically disabling injury, illness, or condition; and</li> <li>• Unmarried and dependent on the member for economic support</li> </ul>
<b>Individuals ineligible for group coverage</b>	<p>If part-time and temporary employees who are not eligible for your group coverage express interest in finding a health plan, they can apply directly to Blue Shield for health coverage through an individual and family plan.</p> <p>Please contact your Blue Shield Account Manager for more information. You can also give your employees a copy of the Individual and Family Plan brochure, included in your Administrator's Kit.</p>

# Enrollment procedures at a glance

For more information on the applications and forms described below, just go to page 44 of this guide.

enrollee    eligibility date    when to report    documents required

enrollee	eligibility date	when to report	documents required
<b>New employees and their dependents</b>	The first billing date after the new employee completes your group's waiting period	Within 31 days of the employee's eligibility date	<ul style="list-style-type: none"> <li>Employee Application</li> </ul>
<b>Current employees transferring from one plan to another</b>	Effective date of your group's open enrollment provision	Open enrollment	<ul style="list-style-type: none"> <li>Subscriber Change Request form</li> <li>Employee Change Transmittal form</li> </ul>
<b>Employees or dependents who lose other group coverage</b>	The date the employee or dependent loses the other group coverage	Within 31 days after the employee or dependent loses the other group coverage	<ul style="list-style-type: none"> <li>The individual's Refusal of Personal Coverage section of the Employee Application</li> <li>Written evidence of loss of coverage</li> <li>Employee Application</li> <li>Subscriber Change Request form (for dependents only)</li> </ul>
<b>Rehired employees</b>	If rehired within six months, the first billing date after the date of rehire. If rehired after six months have elapsed, effective the first billing date after the employee completes your group's waiting period	Within 31 days of the employee's eligibility date	<ul style="list-style-type: none"> <li>Employee Application</li> <li>Employee Change Transmittal form</li> </ul>
<b>Spouses</b>	The date of marriage, or the date they lost their other group coverage	Within 31 days after the marriage, or within 31 days after the loss of their other group coverage	<ul style="list-style-type: none"> <li>Subscriber Change Request form</li> </ul>
<b>Domestic partners</b>	The date of partnership, or the date they lost their other group coverage	Within 31 days after partnership is declared, or within 31 days after the loss of their other group coverage	<ul style="list-style-type: none"> <li>Subscriber Change Request form</li> </ul>
<b>Newborns</b>	The date of birth*	Within 31 days of birth	<ul style="list-style-type: none"> <li>Subscriber Change Request form</li> </ul>
<b>Adopted dependents</b>	The date the member or spouse or domestic partner has the right to control the child's health care	Within 31 days of the date the member or spouse or domestic partner has the right to control the child's health care	<ul style="list-style-type: none"> <li>Adoption papers or a medical authorization form, a health facility minor release form, or a relinquishment form</li> <li>Subscriber Change Request form</li> </ul>
<b>Dependents subject to a court order for medical support</b>	The date the court order is issued (or the date specified in the court order)	Earliest possible date	<ul style="list-style-type: none"> <li>A copy of the court order</li> <li>Subscriber Change Request form</li> </ul>

\* Life insurance has different guidelines for newborns

# Enrollment procedures

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

## Annual open enrollment

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

During open enrollment:

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

This is also the time when you can:

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

You can contact your Blue Shield Account Manager to arrange a benefit meeting for your employees with a Blue Shield representative, who will describe the plan benefits and value-added programs and answer any questions employees may have. These open enrollment benefit meetings are not mandatory – they are only meant to be helpful to you and your employees.

## What forms do employers need to complete during open enrollment?

You need to make sure you sign a Statement of Understanding form, whether you are a new or renewing group. This form is required to make certain that you understand and agree to Blue Shield's policy for pairing products with third-party wrap plans. Please contact your broker or Blue Shield representative for more details.

If you are a renewing group, please submit it with the Contract Change Request form. If you are purchasing or making a change/addition to a standalone vision plan (Vision Standard, Plus, or Deluxe plan), please submit the form with a Master Group Application rather than a Contract Change Request. For details on where to send these forms, please see page 48.

## Enrollment procedures (continued)

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

If an employee does not make a change, they do not have to do anything.

If an employee decides to make a plan change, or add or delete dependents, the employee will have to complete a Subscriber Change Request form (see page 45). Additional forms may be required depending on the circumstance, for example, if the employee has disabled children.

If existing employees who previously refused coverage decide to enroll in a Blue Shield plan, they will need to fill out an Employee Application (see page 45).

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

### **Employees who are absent during open enrollment**

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

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

### **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 a completed Employee Application no later than 31 days after a new employee completes your group's waiting period (see *Where to Send Blue Shield Forms* on page 47).
- Employees and dependents who decline coverage during their initial 31-day enrollment period must complete the Refusal of Personal Coverage section of the Employee Application (see page 45). Please retain a copy of the completed Refusal of Personal Coverage section and forward the original to Blue Shield immediately (see *Where to Send Blue Shield Forms* on page 47).

## Adding dependents

To add a dependent, an employee must complete and submit the Subscriber Change Request form (see page 45).

**Please make sure that HMO and POS members select a Personal Physician for each dependent.**

To add a newborn child, employees must complete and submit the Subscriber Change Request form within 31 days from the child's date of birth. For the first 31 days, HMO members must select for the child a Personal Physician who is with the same IPA or medical group as the mother's Personal Physician. After 31 days, the newborn child will be considered a late enrollee. (See page 22 for more information on late enrollment).

After the employee completes, signs, and dates the Subscriber Change Request form, make sure you complete these six simple steps:

1. Verify that the addition meets eligibility requirements.
2. Make sure the form is properly completed, signed, and dated.
3. Give the employee a copy of the completed form.
4. List the employee's name and Social Security number (or any other identification number) on the Eligibility Change Transmittal (see page 44).
5. Mail or fax the Subscriber Change Request form and the Eligibility Change Transmittal to the address listed in the section Where to Send Blue Shield Forms (see page 47).

## Identifying group-to-group transfers

When your company has more than one group billing unit or health plan, identify group-to-group transfers on the Employee Change Transmittal (see page 44). These changes will appear on your next Group Payment Request. For example, when an employee transfers from a Blue Shield PPO plan to the Blue Shield Access+ HMO during open enrollment, you must submit the Employee Change Transmittal.



### TIP!

You can help us speed up the enrollment process by sending us employee applications immediately after new employees complete them. Simply indicate the employee's future effective date on the application.



# Late enrollment

## Managing late enrollment

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

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

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

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

For enrollment due to the above instances, you must submit an employee application to Blue Shield no later than 31 days from the event. Pre-existing condition exclusion provisions apply, except for enrollees under the age of 19.

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

## Exceptions to late enrollment

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

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

The employee must request enrollment in a Blue Shield group plan within 31 days of losing the other group-sponsored coverage. You should submit requests to add individuals to your Blue Shield group plan within 31 days of the event. Due to state law, Blue Shield cannot consider exceptions to the 31-day time frame for small groups. Please note that a dependent is not considered a late enrollee if:

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

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

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

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

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

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

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

### Please note:

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


## Member ID cards

The member ID card identifies your employee as a Blue Shield member. Your employees should carry their Blue Shield member ID cards with them at all times. We will issue a combination medical and prescription drug identification card to employees approximately two weeks after they enroll in your Blue Shield group plan. If you offer Blue Shield dental coverage, we'll issue them a separate dental ID card.

For additional cards, members can log into **blueshieldca.com** and click on Print Blue Shield ID Cards (temporary), 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 *Order Blue Shield ID Cards* or call member services at **(800) 218-8601**.

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



## HMO ID card sample

			
<small> <b>Provider:</b>            For Provider Connection visit <a href="http://blueshieldca.com/provider">blueshieldca.com/provider</a> </small>			
<small> <b>(800) 424-6521</b> Member Services  <b>(866) 216-9329</b> TTY  <b>(877) 263-8827</b> Mental Health Customer Sec.  <b>(866) 543-3728</b> NurseHelp 24/7  <b>(800) 810-2583</b> To locate providers outside of California         </small>		<small> <b>Members:</b> Use Blue Shield of California preferred providers to receive maximum benefits. In case of emergency, call 911 or seek appropriate emergency care.  <b>Providers:</b> For Provider Connection visit <a href="http://blueshieldca.com/provider">blueshieldca.com/provider</a>. Please file all claims with your local BlueCross BlueShield licensee in whose service area the member received services or where Medicare is primary. File all Medicare claims with Medicare.         </small>	
<small> <b>Blue Shield of California is an independent member of the Blue Shield Association.</b> </small>			
<small> <b>Medical claims to:</b> Blue Shield of California            P.O. Box 272540, Chico, CA 95927-2540         </small>		<small> <b>Submit claims to:</b>            Blue Shield of California            P.O. Box 272540, Chico, CA 95927-2540         </small>	

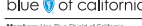

  

							
<small> <b>Subscriber:</b>  <b>John Doe</b>  <b>ID#</b>  <b>XEAJ12345678</b> </small>				<small> <b>Group#</b>  <b>H11337</b> </small>			
<small> <b>Copayments</b>  <b>Office \$15</b> </small>				<small> <b>Effective</b>  <b>07/31/07</b> </small>			
<small> <b>Coverage</b>  <b>Individual</b> </small>				<small> <b>Plan</b>  <b>HMO</b> </small>			
<small> <b>Rx</b>  <b>Language</b>  <b>Spanish</b> </small>				<small> <b>Top message</b> </small>			



## PPO ID card sample

							
<small> <b>Subscriber</b>  <b>John Doe</b>  <b>ID#</b>  <b>XEAJ12345678</b> </small>				<small> <b>Group#</b>  <b>930676</b> </small>			
<small> <b>Effective</b>  <b>07/31/07</b> </small>				<small> <b>Coverage</b>  <b>Individual</b> </small>			
<small> <b>Plan</b>  <b>PPO</b> </small>				<small> <b>Rx</b>  <b>Language</b>  <b>Spanish</b> </small>			
<small> <b>Top message</b> </small>				<small> <b>Medical claims to:</b> Blue Shield of California            P.O. Box 272540, Chico, CA 95927-2540         </small>			





  

			
<small> <b>Members:</b> Use Blue Shield of California preferred providers to receive maximum benefits. In case of emergency, call 911 or seek appropriate emergency care.  <b>Providers:</b> For Provider Connection visit <a href="http://blueshieldca.com/provider">blueshieldca.com/provider</a>. Please file all claims with your local BlueCross BlueShield licensee in whose service area the member received services or where Medicare is primary. File all Medicare claims with Medicare.         </small>			
<small> <b>Blue Shield of California is an independent member of the Blue Shield Association.</b> </small>			
<small> <b>Medical claims to:</b> Blue Shield of California            P.O. Box 272540, Chico, CA 95927-2540         </small>		<small> <b>Submit claims to:</b>            Blue Shield of California            P.O. Box 272540, Chico, CA 95927-2540         </small>	



## Dental PPO ID card sample

							
<small> <b>Subscriber</b>  <b>John Doe</b>  <b>ID#</b>  <b>J12345678</b> </small>				<small> <b>Plan</b>  <b>Dental HMO</b> </small>			
<small> <b>Effective date</b>  <b>01/01/08</b> </small>				<small> <b>Card issue date</b>  <b>01/01/08</b> </small>			
<small> <b>Dentist</b>  <b>Anthony D. Kavorinos</b>  <b>Dentist ID</b>  <b>00000042895</b>  <b>Dental Center</b>  <b>San Francisco Dental</b> </small>				<small> <b>Dental Identification Card</b> </small>			





  

			
			
<small> <b>Carry this identification card with you at all times and present it whenever you or one of your enrolled dependents receives dental services. Read your Evidence of Coverage booklet, which sets forth the benefits, limitations, and exclusions of your dental plan contract.</b> </small>			
<small> <b>Blue Shield of California is an independent member of the Blue Shield Association.</b> </small>			
<small> <b>Benefits of the Dental Plan, other than emergency care, are available only when you receive covered services from the Dental Center selected by the member. Benefits for specialty covered services are provided only on referral from your Dental Center.</b> </small>		<small> <b>Network benefits apply when you receive covered services from a network dentist. In-network benefits are paid based on applicable copayment. For non-network benefits, you will be responsible for a specified maximum amount and will be responsible for the remainder of the dentist's billed charges.</b> </small>	
<small> <b>Submit claims to:</b>            Blue Shield of California            P.O. Box 272540, Chico, CA 95927-2500         </small>		<small> <b>Submit claims to:</b>            Blue Shield of California            P.O. Box 272540, Chico, CA 95927-2500         </small>	

## Dental HMO ID card sample

							
<small> <b>Subscriber</b>  <b>John Doe</b>  <b>ID#</b>  <b>D12345678</b> </small>				<small> <b>Plan</b>  <b>Dental PPO</b> </small>			
<small> <b>Effective date</b>  <b>01/01/08</b> </small>				<small> <b>Card issue date</b>  <b>01/01/08</b> </small>			
<small> <b>Dental Identification Card</b> </small>				<small> <b>Medical claims to:</b> Blue Shield of California            P.O. Box 272540, Chico, CA 95927-2500         </small>			

			
			
<small> <b>Carry this identification card with you at all times and present it whenever you or one of your enrolled dependents receives dental services. Read your Evidence of Coverage booklet, which sets forth the benefits, limitations, and exclusions of your dental plan contract.</b> </small>			
<small> <b>Blue Shield of California is an independent member of the Blue Shield Association.</b> </small>			
<small> <b>Network benefits apply when you receive covered services from a network dentist. In-network benefits are paid based on applicable copayment. For non-network benefits, you will be responsible for a specified maximum amount and will be responsible for the remainder of the dentist's billed charges.</b> </small>		<small> <b>Submit claims to:</b>            Blue Shield of California            P.O. Box 272540, Chico, CA 95927-2500         </small>	

### **Credit for prior coverage and pre-existing condition exclusions**

Blue Shield will credit any pre-existing condition waiting period by one month for every month of prior coverage, as long as any break in coverage does not exceed 63 days from the prior individual plan or 180 days from the prior employer-sponsored group plan. An employer's eligibility waiting period is not counted as a break in 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).

Pre-existing conditions will be calculated based on the employee's enrollment date with the plan, which includes any employer waiting period. Also, Blue Shield will not apply pre-existing condition exclusions to pregnancy or maternity care, or to enrollees under the age of 19.

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

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

# Employee status changes

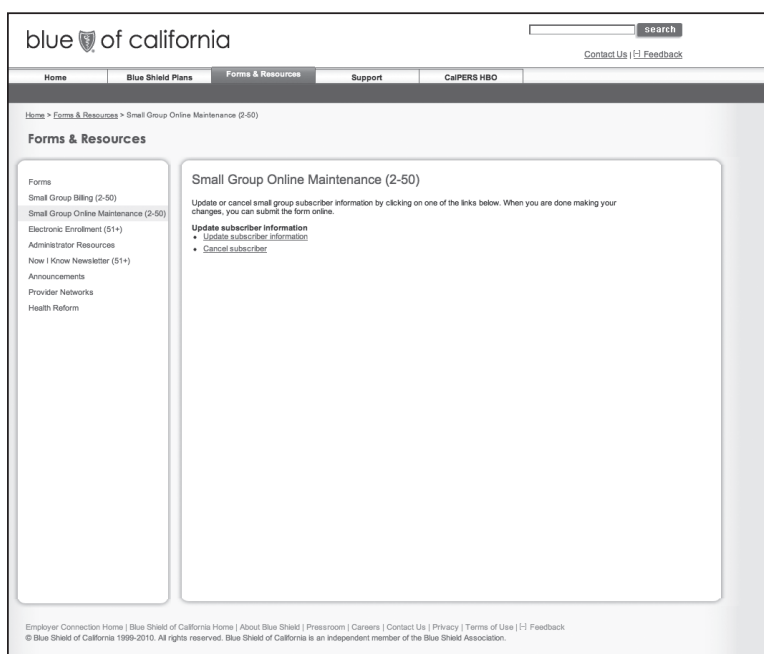
Here's how to keep your employee information current:

## Online subscriber change requests

We've made it easy to maintain your group's most up-to-date information. You can update or cancel subscriber information any time by simply going to [blueshieldca.com/employer](http://blueshieldca.com/employer) and clicking on *Small Group Online Maintenance*, then clicking on *Update* or *Cancel Subscribers Online*, and choosing the online service you want

### Update a subscriber

To update a subscriber, be sure to include the subscriber's name, the group number, the subscriber ID, and the updated information. After filling in the required fields, click on *Continue* to review the information prior to submitting it. You can print this page for your records. When you click on *Submit*, your information will be sent to Blue Shield. A confirmation screen lets you know your subscriber update was successfully submitted and processed by Blue Shield. You can then update another subscriber or go back to the homepage.



### Cancel a subscriber

To cancel a subscriber, you'll need the customer number, the group number, the subscriber ID number, and a reason for cancellation. After filling in the required fields, click on *Continue* to review the information you entered. You can print this page for your records. When you click on *Submit*, the cancellation request will be sent to Blue Shield. A confirmation screen lets you know that the cancellation request was successfully submitted and processed by Blue Shield. You can then cancel another subscriber or go back to the homepage.

Note: Keep your confirmation number handy for easy reference.

## Name and address changes

An employee whose name is legally changed, who wants to make a name correction, or who has moved to a new home address should complete a Subscriber Change Request form (see page 45), and submit it to you. You will then need to fax or mail the form to the Membership Eligibility Processing Unit, listed in the Where to Send Blue Shield Forms section (see page 47).

## Leave of absence

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

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

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

The allowable length of a leave of absence is determined by your company's personnel policy. Therefore your company policy determines when the employee on leave is terminated. When you terminate an employee, you must notify Blue Shield by calling the Group Employer Services Department number in the contact information chart (see page 6). When an employee on leave is terminated, he or she may qualify for continuation coverage in the same manner as a terminated employee who was actively working on his or her last day of coverage.

## Divorce or legal separation

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

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

For more information, see the Coverage Cancellation section starting on page 29.

## Termination of domestic partnership or divorce of same-gender spouse

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

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

You can administer address changes over the phone by calling our Group Employer Services Department at **(800) 325-5166**.

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## Ownership or group name change

Be sure to keep your small-group information current, especially if you have a change of ownership or a name change. This would include the sale of your business that results in any of the following: new ownership, new business entity, merging with another business entity and becoming a subsidiary, sale of assets and liabilities of that entity, or a simple name change

or sale of company stock. For any of these examples, please contact your broker or your Blue Shield small-group Account Manager. Your Blue Shield small-group Account Manager will walk you through a 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:

## Preferred providers

An employee who uses a preferred provider should never have to complete a claim form, because these providers bill Blue Shield directly. In the rare instance when a preferred provider requests payment from the employee, the employee should ask the provider to call the number listed on their Blue Shield 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 preferred provider should bill Blue Shield directly.

## Non-preferred providers

If a non-preferred 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 (see page 47) to Blue Shield at the address listed in the Where to Send Blue Shield Forms section (see page 47).

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

## Explanation of Benefits

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

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

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 on and clicking *My Health Plan*. They can also change their Personal Physician, order replacement ID cards, and verify their benefits for certain services.

# 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 representatives on behalf of employees can contact our Member Services 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 into **blueshieldca.com** and click *File a Grievance* 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, for these reasons:

- Companies that sell individual coverage require a review of an applicant's medical history.
- An individual is not eligible for a guaranteed-issue individual plan as required by federal law (HIPAA) unless all group coverage options are exhausted, including COBRA and Cal-COBRA.

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

- Report the coverage cancellation by calling our Group Employer Services Department or by filling out an Employee Change Transmittal form (see page 44).
- Notify us prior to each individual's last day of eligibility, whenever possible.

### Cancelling employee and dependent coverage

#### Employee coverage cancellation

Employees are no longer eligible for Blue Shield group coverage when their employment is terminated or their employment hours are reduced to fewer than 30 hours per week, unless they are covered under provisions of state law that allow coverage of part-time employees. To cancel an employee's coverage, you have three options. You can:

1. Simply log on to [blueshieldca.com/employer](https://blueshieldca.com/employer) and click *Small Group Online Maintenance*, then choose *Update* or *Cancel Subscribers Online*; or
2. Call our Group Employer Services Department; or
3. Use our paper form process and following these steps:
  - a. Fill out an Employee Cancellation Transmittal Request form (see page 44).
  - b. List the employee's name, Blue Shield ID number or Social Security number, and employment termination date.

- c. Mail or fax the Employee Cancellation Transmittal Request form to Blue Shield's Membership Eligibility Processing Unit at the address listed under Where to Send Blue Shield Forms (see page 47).

Cancellation requests must be submitted within 30 days of the termination date.

Helpful hints:

- When an employee's coverage is cancelled, all covered dependents lose eligibility, and their group coverage is cancelled automatically.
- If an employee voluntarily cancels his or her group coverage (when not terminating employment with your company), a Refusal Of Coverage form must be submitted. If the employee later wishes to re-enroll, the employee must comply with the late enrollee guidelines, outlined on page 22, or wait until open enrollment.
- Employees must be a resident of California in order to be eligible for COBRA coverage if enrolled in an HMO, POS, or Active Choice plan. However, non-residents may be eligible to transfer to a PPO plan if you offer one. Please contact your Blue Shield account manager about continuation coverage for your out-of-state employees.
- If you are cancelling an employee on a vision plan that is not a rider to his or her Blue Shield medical coverage, use the form that accompanies your bill and return it to the sender (the vision plan administrator). If you have any questions, call the vision plan administrator at (877) 601-9083.
- When a specialty product is sold with medical coverage, and the group elects to cancel its medical coverage, we will cancel only its medical coverage and maintain the dental, life, or vision coverage unless specifically requested to cancel the specialty product.

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

## Dependent coverage cancellation

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

Coverage for dependent children must be cancelled when they reach age 26. Cancellation is effective the first day of the month following the birthday.

The following dependents (a same-gender spouse and his or her children) may be eligible for continued coverage under COBRA or Cal-COBRA:

- A spouse who divorces or legally separates from a covered employee and becomes ineligible for group coverage.
- The subscriber's dependent children if the subscriber decides to cancel the dependent children from his or her coverage.
- When a domestic partnership terminates, group coverage of the employee's domestic partner and his or her children will terminate at the end of the month in which the domestic partnership termination occurs. The employee's domestic partner and children may be eligible for continued coverage under Cal-COBRA. For details, see the Employee Status Changes section on page 26.
- When a same-gender spouse is divorced, group coverage of the employee's same-gender spouse and his or her children will terminate at the end of the month in which the divorce occurs. The employee's same-gender spouse and children may be eligible for continued coverage under Cal-COBRA. For details, see the Employee Status Changes section on page 27.

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

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

1. Have the employee complete a Subscriber Change Request form (see page 45) and list the name(s) of the dependent(s) to be disenrolled and the date(s) of cancellation. The employee should complete this form during the month the dependent becomes ineligible for coverage.
2. Verify that the form is properly completed, signed, and dated, and give the employee a copy of the form.
3. List the employee's name and subscriber ID number on the Employee Change Transmittal form (see page 44).
4. Mail or fax the Subscriber Change Request and Employee Change Transmittal forms to our Membership Eligibility Processing Unit. The unit's address and fax number are listed under Where to Send Blue Shield Forms (see pages 47 and 48).

If you are adding an employee to a vision plan that is not a rider with our medical coverage, use the form that accompanies your bill, and return it to the sender (the vision plan administrator). If you have any questions, call the vision plan administrator at **(877) 601-9083**.

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 groups. You can also give notice of cancellation by calling our Group Employer Services Department.

# State Cal-COBRA and federal COBRA continuation coverages

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

## General guidelines

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

COBRA 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 must wait until the first 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.

## Cal-COBRA coverage

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

Under Cal-COBRA, you are required to notify Blue Shield within 31 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 (see page 44) and mail or fax it to the contact information listed under Where to Send Blue Shield forms (see page 48). After we receive the notification, we will mail information to the employee regarding Cal-COBRA benefits, rates, and enrollment.

Rest assured, our dedicated Cal-COBRA team will perform these administrative and membership duties for your affected employees:

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

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 employers' group benefits policy. Any changes or cancellation of the employer's coverage will also apply to Cal-COBRA enrollees.

**Important note:** To change your Cal-COBRA administration, you must notify Blue Shield. Please submit a letter to our Cal-COBRA Department at the address shown in the Contact Information chart on page 6. We will help you make all procedural changes.

## COBRA coverage

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

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

## COBRA disability extension

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

1. Disabled on or before the date of termination or reduction in hours of employment, **OR**
2. Determined to be disabled under the Social Security Act 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.

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

## Cal-COBRA coverage for COBRA enrollees

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

- If elected, the Cal-COBRA coverage will begin after the COBRA coverage ends, and will be administered by Blue Shield's Cal-COBRA administrator as described in the Cal-COBRA Coverage section on page 31.

- COBRA enrollees must exhaust all the COBRA coverage to which they are entitled before they can become eligible to continue coverage under Cal-COBRA, except for domestic partners when the partnership terminates, and same-gender spouses when divorce occurs.
  - When a partnership terminates, same-gender spouses divorce, or an employee dies, the domestic partner or same-gender spouse may apply for continuation of group coverage under Cal-COBRA.
  - Cal-COBRA coverage is immediately available, because a domestic partner and a same-gender spouse do not have COBRA eligibility unless the employee elects COBRA and includes the domestic partner or same-gender spouse as a dependent.

### Notification requirements for COBRA plan administrators

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

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

Effective March 1, 2009, the American Recovery and Reinvestment Act of 2009 requires that employers subject to COBRA and health plans and insurance companies subject to Cal-COBRA offer COBRA and Cal-COBRA enrollees a 65% subsidy. This subsidy is initially paid by employers and health plans/insurance carriers, however these entities may recover the subsidy by taking the subsidy amount as a credit on their quarterly employment tax returns. The subsidy is available to employees who were involuntarily terminated from healthcare coverage between September 1, 2008, and December 31, 2009. The subsidy is available for up to nine months.

# Coverage options for employees and retirees who have Medicare coverage

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

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

## Active employees

### Employers with fewer than 20 employees

If Medicare is the primary coverage, and the employer's group health plan is secondary for employees with Medicare Parts A and B, this can qualify a group for a reduced premium rate from their health plan for medical benefits for these Medicare-eligible employees. You will be required to supply Blue Shield with validation of small-group status at each renewal to continue to qualify for the reduced rates.

If copies of your DE-6s are not received within 30 days of your renewal effective date, you will not receive a reduced rate for these employees for their renewal year. If you have employees covered by Medicare Parts A and B, and are not currently receiving the reduced rate, please submit a copy of the employee's Medicare card in addition to your DE-6s.

Please note: Reduced premium rates are only available if the employee's enrollment in Medicare Parts A and B is due to their age. Medicare enrollment due to disability or end-stage renal disease does not qualify for reduced premium rates.

### 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.

### HIPAA guaranteed issue

Once your former employees have exhausted their COBRA or Cal-COBRA coverage, they may qualify for an individual and family plan based on guaranteed issue (GI).

- This GI plan under HIPAA is only available after the member exhausts COBRA or Cal-COBRA benefits if they had at least 18 months of group coverage, and only if the most recent coverage was through a group (COBRA and Cal-COBRA are considered group coverage).
- Your former employees may apply for this individual coverage based on GI from any carrier if they apply within 63 days of exhausting COBRA or Cal-COBRA coverage.

### Extension of benefits for disabled members

Extension of benefits is only granted to members who become totally disabled while covered under the plan, and when a 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 any of the following dates:

- 12:01 a.m. on the day following a 12-month period from the date coverage terminated.
- The date when the covered person is no longer totally disabled.
- The date when the covered person's maximum benefits are reached.
- The date when a replacement carrier provides coverage to the person who is not subject to a pre-existing condition exclusion. The time the person was covered under this plan will apply toward the replacement plan's pre-existing condition exclusion.

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

## Filing for an extension of benefits for disabled members

To file for an extension of benefits:

- The **employee** must complete a Subscriber Statement of Disability form (see page 46), and
- **You** must complete a Notice of Total and Permanent Disability form (see page 44) and then mail both forms to the Program Management/Extension of Benefits address listed under Where to Send Blue Shield Forms. (see page 48).
- The disabled member's **Primary Physician** must submit an Attending Physician Statement of Disability form (see page 46) to Blue Shield at the address listed in Where to Send Blue Shield Forms (see page 47).

Blue Shield chooses to offer reduced rates to our clients to help mitigate the cost of coverage. To continue to receive reduced rates, please provide us with a copy of your DE-6 (two quarterly statements) to confirm your status as a small group, as defined by Medicare.

For additional coverage options for employees and dependents, please go to [blueshieldca.com/employer](https://blueshieldca.com/employer), click on *Health Plans*, and choose *Small Groups (2-50)*. You can also contact your Broker or Blue Shield Account Manager to learn about:

- Blue Shield individual and family plans (IFP)
- Blue Shield individual conversion plans
- Medicare Coordination of Benefits (COB) plan or Blue Shield 65 Plus<sup>SM</sup> (HMO) for Individuals with Medicare
- Individual Senior Guard Plan for retirees without Medicare coverage

To keep our promise of excellent service, we have 12 experienced teams dedicated to your group plan administration needs, including two teams that concentrate specifically on group reconciliation and billing issues.

# Managing your medical coverage

## Billing procedures

The following sections explain our billing procedures and requirements.

### Paying your bill

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

- Submit any cancellation requests within 30 days of the termination date. Retroactive cancellations that exceed 30 days will not be approved.
- Verify monthly that your changes are accurately reflected on the Group Payment Request.
- Send the Group Summary page with your monthly dues to the address listed on your monthly bill.

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

If you submitted additions, deletions, or transfers during the billing period, you do not need to make any billing adjustments if they do not appear on your monthly bill. Simply pay the amount shown on your current 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 the number listed on your Group Payment Request.

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

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



### TIP!

Reporting changes, additions, and deletions to your group's coverage in a timely manner will help avoid unnecessary delays. It's easy when you use our online tool.



### 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 deletions

If an employee is terminated during the month:

- Please submit an Employee Cancellation Transmittal (see page 44) immediately after the employee's termination date.
- The employee's coverage will remain in force until the end of the billing period, and dues are payable for that period.
- The terminated employee will be deleted from the next 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.

## Easy\$Pay Online is now available

Blue Shield offers an easy-to-use online payment tool for you and your group. Register your group online, and automatically pay your bills by scheduling recurring monthly payments or one-time payments. You can view member details, easily keep track of payment status, and view up to 12 months of payment history – all in one convenient online location.

To register:

- Just go to [blueshieldca.com/employer](http://blueshieldca.com/employer) and click on *Administrator Resources*. Then scroll down to the *Quick Information* section and click on *Pay Monthly Premiums*. You will then be prompted to register at [ebilling-poc.crmondemand.com/ebilling](http://ebilling-poc.crmondemand.com/ebilling).
- Upon registration, click on *Register Small Group Admin*, and key in your customer number and billing unit number. You will also need your last bill amount and renewal date information.
- You will be prompted to the *User Credential Information* screen, where you'll fill out detailed information as the benefit administrator, and create a User ID and password for your group. Keep in mind that the User ID and password may contain characters such as a hyphen or @ symbol.
- Verify that the group number and billing units are correct. (If they're not, click *No* and you will be redirected to call Customer Service.)

Don't forget to give us your e-mail address, so you can take advantage of e-mail notifications.

### How to make a payment

Making an online payment is simple, whether it's one-time or recurring. Once you submit your registration, you'll receive an e-mail confirming your enrollment. Log in as instructed, then enter the bank account(s) you'd like to use for payment, and proceed.

To add a bank account:

- Choose *Payments* and select *Payment Accounts* to add bank account information.
- Upon filling out all the required fields, click *Save* to save a payment account for future use.

To make a one-time payment:

- Access the *Quick Links* and click on *Make a One-Time Payment*.
- After filling out the *Payment Amount* information, click on *Pay Now*.
- Upon reviewing all the payment information, click on *Continue* and choose a bank account from the drop-down menu.
- Look over all the information, then confirm by clicking on *Submit* – and your payment is easily processed.

One-time payments are made on the current date on which you are paying your bill.

To set up a recurring payment:

- Under *Quick Links*, choose the *Setup Recurring Payments* link and select the payment account, recurring payment information, and effective period.
- Click *Update Recurring Payment Account* to successfully complete your setup.

# Delinquency

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

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

## Late payment notice

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

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

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

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# Cancellation procedures

## Requesting cancellation of your group account

We request 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.

## Administrative cancellation due to under enrollment

If your group no longer meets the eligibility requirements defined by state law (see the Eligibility Requirements section starting on page 13), you will be notified prior to your renewal and given 30 days to bring your account into compliance. If your group is not compliant with eligibility requirements, your small-group coverage will not be guaranteed renewable.

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

## Nonpayment of dues

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

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

Please note: Reinstatement requests may be considered at our sole discretion, and are not guaranteed. You may submit a written request for consideration to the Small Group Cancellation e-mail box at **LgpCan01@blueshieldca.com**.

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. 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 following information:

- On the upper right-hand corner of the application, fill in the group number, plan number, and the effective date for coverage.
- The effective date for an added employee or dependent must be the first day of the month following your group's benefit waiting period.
- Mail or fax new enrollment applications to Blue Shield Dental Member Services.

### Employee status change

You are responsible for maintaining accurate eligible employee information.

- A Subscriber Change Request form (C675-1) must be completed when there is a change in status to an employee, or their dependents, spouse, or domestic partner.
- In cases of births, adoptions, marriages, and divorces, employees must submit the Subscriber Change Request form no later than 31 days after the change.
- If the employees do not submit the form within 31 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.

- Employees with family coverage should notify Blue Shield when a dependent child reaches age 19. At that time the dental coverage would end, unless the dependent child is a full-time student. A Full-time Student Certification form (C13125) would need to be completed and a copy of the dependent's class records is required to verify the student's full-time status.

### Invoice procedures

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

### Open enrollment

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

### Dental HMO provider change

Dental HMO members may change their current dental provider at any time by calling Dental Member Services at **(800) 585-8111**. Changes will take effect on the first of the following month.

## Submitting a claim

### Dental HMO claims handling

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

## Dental PPO claims handling

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

## Nationwide dental provider network

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

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

- Going to [blueshieldca.com](http://blueshieldca.com) to find a provider.
- Calling Dental Member Services at **(800) 585-8111** to request a provider directory.

## Forms

Forms for administering group dental benefits are listed on page 46. You can print them from [blueshieldca.com](http://blueshieldca.com) or order them by contacting your Blue Shield Account Manager.

## Dental Member Services

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

### Dental Member Services

Dental HMO: **(800) 585-8111**

Dental PPO: **(888) 702-4171**

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

425 Market St., 12<sup>th</sup> Floor

San Francisco, CA 94105

## Grievance process

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

Blue Shield of California  
Dental Plan Administrator  
425 Market St., 12<sup>th</sup> Floor  
San Francisco, CA 94105

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

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

## How to manage your group vision benefits

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

### Enrolling employees and dependents

If you purchased a Vision Basic 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 Vision Basic plan with your medical coverage, you can submit a new Employee Application (C15390) to add new employees, their spouse/domestic partner, and dependents.
- Single bill for both medical and vision plans.

If you have a Vision Standard, Vision Plus, or Vision Deluxe plan, with or without a medical plan, you can also use the medical master group application. Plan administration is fast and easy.

#### Follow these steps:

1. Send an e-mail to [groupservices@mesvision.com](mailto:groupservices@mesvision.com) to request a login ID and password. Include the following information: your group name, account number, administrator's name/title, phone number, e-mail, and mailing address.
2. After receiving your login ID and password, log in to [blueshieldcavision.com](https://blueshieldcavision.com), and click on *Benefit Administrators* to manage your employees and their dependents vision benefits.

Or, you can use the forms included with your monthly bill.

### Employee status change

You are responsible for maintaining accurate eligible employee information.

- Each month you will receive a premium billing statement, which includes all eligible members for the next month. Review your premium billing statement to confirm accurate eligible employee information.
- A Subscriber Change Request form (C675-1) must be completed when there is a change in status to an employee's dependents, spouse, or domestic partner.

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

### Invoice procedures

Fax or mail membership changes to Blue Shield Vision Member Services. These 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 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 producer or Blue Shield account 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](https://blueshieldca.com).
- For out-of-state providers, go to [blueshieldcavision.com](https://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 ordered on [blueshieldca.com/employer](https://blueshieldca.com/employer), under *Vision Plans*. Or, you can call Vision Member Services at **(877) 601-9083**.

## Submitting a claim

A claims form is not necessary when using a network provider. When using a non-network provider, the employer, employee, and/or provider may be required to complete a Vision Claims form (C-4669-61). Please refer to the claims 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 claims form.

Mail completed claims form(s) and documentation to:

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

## Forms

Forms for administering group vision benefits are listed on page 46. You can print them from [blueshieldca.com](http://blueshieldca.com) or order them by contacting your Blue Shield Account Manager.

## Vision Member Services

Vision Member Services can assist you with questions about eligibility, claims, or ordering forms and/or directories. For questions about your plan or renewal rates, please contact your Broker or Blue Shield Account Manager.

### Vision Member Services

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

## Grievance Process

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

# How to manage your group life insurance benefits

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 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 rates, unless you self-report your life insurance billing.

## 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.

Open enrollment is not available for Blue Shield life insurance plans. This means that employees who did not apply for coverage when they were first eligible and have not had an interim special event (such as marriage, divorce, or adoption), may be required to submit evidence of insurability to obtain coverage.

## Life insurance groups of 2 to 9 members

Please note, you must use a separate set of forms, as coverage for these groups is administered and underwritten by a small-group employer trust. Please call **(888) 646-0789** to request the proper forms.

## 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 these beneficiary designation and affidavit forms directly to the Blue Shield life insurance claims department only when submitting a life insurance and AD&D insurance, or waiver of premium claim. Please note that life insurance groups of 2 to 9 members must use separate forms as described in the section above.
- You are responsible for maintaining Statements of Domestic Partnership, if applicable.

## 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

*Certificates of Insurance* are automatically generated and mailed to each employee as they are enrolled under your policy. If you are set up for self-billing for life insurance premium, you will receive standard *Certificates of Insurance* for distribution to covered employees.

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

## How to submit a Waiver of Premium claim

If your employees become disabled before age 60, they may be eligible for waiver premium.

- Employer, employee, and attending physician will need to complete the Waiver of Premium claims form (ABU1182).
- Mail completed Waiver of Premium claims forms and documentation to:

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

Blue Shield Life will require re-verification of total disability every two years.

\* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life). Group term life insurance for groups of 2 to 9 eligible employees is administered and underwritten through a small group employer trust.

## How to submit an Accelerated Death Benefit (ADB) claim

If your employee becomes terminally ill before the age of 60 he or she may be eligible for an Accelerated Death Benefit. The employer, employee, and/or attending physician will need to complete the Accelerated Death Benefit claims form (ABU1139).

Mail completed claims form and documentation to:

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

Please remember that life insurance groups with 2 to 9 members must use a separate set of forms, as coverage for these groups is administered and underwritten by a small group employer trust. Please call **(888) 646-0789** to request the proper forms.

## Forms

Forms for administering group life insurance are listed on page 46. You can print them from [blueshieldca.com](http://blueshieldca.com) or order them by contacting your Blue Shield Account Manager. For questions about your plan or new rates, please contact your Broker or Blue Shield Account Manager.

### Blue Shield Life Member Services

Phone **(888) 800-2742**

Fax (800) 329-2742

Monday through Friday, 8:30 a.m. to 5 p.m.

For life insurance groups with 2 to 9 members:

Phone **(888) 646-0789**

Fax (800) 250-1786

Monday through Friday, 8:30 a.m. to 5 p.m.

## Grievance process

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

Blue Shield Life  
Attention Appeals and Grievances  
4203 Town Center Blvd.  
El Dorado Hills, CA 95762

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

# Forms

To get more copies of any of the forms included in the Forms section or for any additional forms which you may need, you can go to [blueshieldca.com/employer](https://blueshieldca.com/employer), under *Forms*. If you need additional assistance, you can always contact your Blue Shield Account Manager.

## employer forms

<b>Master Group Application (Form C15385)</b>	Employers need to complete the appropriate Master Group Application. If you are purchasing or making a change/addition to a standalone vision plan (Vision Standard, Plus, or Deluxe plan), please use this Master Group Application.
<b>Employer Notification of Qualifying Event Under Cal-COBRA (Form C13140)</b>	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.
<b>Continuing Group Coverage After Federal COBRA Cal-COBRA Election (C18157)</b>	Use this form to continue an employee's group coverage under Cal-COBRA if the employee has exhausted coverage under the federal COBRA.
<b>Request for Contract Change (Form C15782)</b>	Use this form to submit open enrollment changes during the renewal period. If you are purchasing or making a change/addition to a standalone vision plan (Vision Standard, Plus, or Deluxe plan), please use a Master Group Application rather than a Contract Change Request.
<b>Verification and Statement of Understanding (Form C20283)</b>	This form ensures that the group both acknowledges and agrees to Blue Shield's policy for pairing our products with third-party wrap plans. It is used for both new and renewing groups. If you are a new group, please submit this form with the Master Group Application. If you are a renewing group, please submit this form with the Contract Change Request form. If you are purchasing or making a change/addition to a standalone vision plan (Vision Standard, Plus, or Deluxe plan), please submit this form with a Master Group Application rather than a Contract Change Request.
<b>Employee Change Transmittal (Form C3843)</b>	Each month, use this form to complete eligibility changes for every billing unit within the group. Note: We've included extra copies of this form in your Administrator Kit, so you can photocopy it and submit it to Blue Shield each month with any changes.
<b>Employee Cancellation Transmittal Request (Form A36965)</b>	As a group contact, complete this form to submit information on employee terminations/cancellations.
<b>Notice of Total and Permanent Disability (Form C4424)</b>	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

<p><b>Employee Application for Groups With 2 to 50 Employees (Form C12914)</b></p>	<p>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.</p>
<p><b>Employee Health Statement for Groups with 2 to 14 Enrolling Employees (Form C15825)</b></p>	<p>For groups with 2 to 14 enrolling employees and non-guaranteed-issue groups, employees need to complete and submit this form in addition to the Employee Application.</p>
<p><b>Refusal of Coverage (Form C19927)</b></p>	<p>Employees should use this form when they, their spouse, domestic partner, or dependent(s) are eligible but refusing your group coverage.</p>
<p><b>Subscriber Change Request (Form C675-1)</b></p>	<p>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.</p>
<p><b>Group Continuation Coverage (COBRA) Election (Form C11825-RTM)</b></p>	<p>When a qualified beneficiary elects to participate in COBRA, he or she must complete this form. Note: This form is for PPO members only.</p>
<p><b>HMO COBRA Application (Form C12559 RTM)</b></p>	<p>If a qualified beneficiary elects to participate in COBRA, he or she must complete this application. Note: This form is for HMO and POS members only.</p>
<p><b>Continuing Cal-COBRA under Blue Shield of California Cal-COBRA Take-Over (Form C14755)</b> <b>Cal-COBRA Election (Form 13141)</b> <b>Cal-COBRA Dental Election (Form 18156)</b></p>	<p>Employees should complete these forms to elect Blue Shield of California over Cal-COBRA coverage from a prior carrier.</p>

To get additional copies of forms for your employees, go to [blueshieldca.com/employer](https://blueshieldca.com/employer) and click on *Employee Forms*. You can then view, download, and print any form.

## employee forms (continued)

<b>Subscriber's Statement of Claim (Form CLM-14850)</b>	Employees should use this form when the provider of service does not submit their claim 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.
<b>Subscriber's Statement of Claim Blue Shield Life (Form CLM-15481)</b>	Employees should use this form when the provider of service does not submit their claim directly to 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 of California Life & Health Insurance Company (Blue Shield Life). This is for Blue Shield Life plans only.
<b>Declaration of Disability for Over-Age Dependent Children (Form C3674)</b>	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.
<b>Attending Physician Statement of Disability (Form C4425)</b>	To file for an extension of disability benefits, the employee's Personal Physician must complete and submit this form to Blue Shield. In addition, employees must complete a Subscriber Statement of Disability form and you must fill out a Notice of Total and Permanent Disability form.
<b>Subscriber Statement of Disability (Form C12198)</b>	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.
<b>Authorization to Disclose Personal &amp; Health Information to a Third Party (C15625)</b>	
<b>Dental Claim Form C11716</b>	Employees should complete this form to submit a dental claim for services received from a non-network provider.
<b>Vision Claim Form C-4669-61</b>	Employees should complete this direct reimbursement form for services received from a non-network provider.
<b>Vision Plan Information Card ABU15756-CA (for California members), ABU15756-OOS (for members outside California)</b>	The card is not required, but has useful information for both the member and the provider.
<b>Life insurance forms</b>	Forms for administering group life insurance and/or AD&D insurance benefits are listed below. They can be easily downloaded and printed from <a href="http://blueshieldca.com">blueshieldca.com</a> , or ordered by contacting your Blue Shield account manager.
<b>Accelerated Death Benefit Claim (ABU1139)</b>	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.
<b>Life &amp; AD&amp;D Waiver of Premium Claim (ABU1182)</b>	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.
<b>Life Insurance Proof of Death Claim (ABU1180)</b>	Employers should complete this form for the beneficiary or dependent and submit an original certified death certificate.
<b>Conversion to Individual Policy from Group Life Insurance (CP1020)</b>	Employer and employee should complete this form when changing from group life insurance to individual life insurance.
<b>Life &amp; AD&amp;D Statement of Domestic Partnership (C15388)</b>	Employees should complete this form when they have additions, deletions, and other changes to their coverage.
<b>Life &amp; AD&amp;D Beneficiary Change Request (ABU1165)</b>	Employees should complete this form when they have additions, deletions, and other changes to their coverage.

## Where to send completed **employee** forms

name	number	where to mail	where to fax
<b>HMO COBRA Application</b>	C12559-RTM		
<b>Group Continuation Coverage (COBRA) election</b>	C11825-RTM		
<b>Continuing Cal-COBRA under Blue Shield of California Cal-COBRA Take-Over</b>	C14755	Membership Eligibility Processing Unit Blue Shield of California P.O. Box 629014 El Dorado Hills, CA 95762-9014	(916) 350-8800
<b>Cal-COBRA Election</b>	C13141		
<b>Cal-COBRA Dental Election</b>	C18156		
<b>Declaration of Disability for Over-age Dependent Children</b>	C3674		
<b>Subscriber's Statement of Claim Blue Shield Life</b>	CLM-15481		
<b>Subscriber's Statement of Claim</b>	CLM-14850		
<b>Employee Application</b>	C12914	Membership Eligibility Processing Unit Blue Shield of California P.O. Box 3008 Lodi, CA 95241-1912	(209) 367-6475
<b>Refusal of Coverage</b>	C19927		
<b>Subscriber Change Request</b>	C675-1		
<b>Employee Cancellation Transmittal Request</b>	A36965		
<b>Subscriber Statement of Disability</b>	C12198	Blue Shield of California Program Management Office/Extension of Benefits 4203 Town Center Blvd. El Dorado Hills, CA 95762-9806	(800) 431-2809
<b>Attending Physician Statement of Disability</b>	C4425		

## Where to send completed **employer** forms

name	number	where to mail	where to fax
<b>Request for Contract Change</b>	C15782	Membership Eligibility Processing Unit Blue Shield of California P.O. Box 3008 Lodi, CA 95241-1912	(209) 367-6603
<b>Master Group Application</b>	C15385	Vision Plan Administrator c/o Blue Shield of California 345 Baker St. Costa Mesa, CA 92626	(714) 619-4665 or bscgroupimplementation@mesvision.com
<b>Verification and Statement of Understanding</b>	C20283	Membership Eligibility Processing Unit Blue Shield of California P.O. Box 3008 Lodi, CA 95241-1912	(209) 367-6603
<b>Employee Change Transmittal</b>	C3843	Membership Eligibility Processing Unit Blue Shield of California P.O. Box 3008 Lodi, CA 95241-1912	(209) 367-6475
<b>Employer Notification of Qualifying Events under Cal-COBRA</b>	C13140	Blue Shield of California Cal-COBRA Administration P.O. Box 629009 El Dorado Hills, CA 95762-9009	(916) 350-7480
<b>Continuing Group Coverage after Federal COBRA Cal-COBRA Election</b>	C18157	Blue Shield of California Cal-COBRA Administration P.O. Box 629009 El Dorado Hills, CA 95762-9009	(916) 350-7480
<b>Notice of Total and Permanent Disability</b>	C4424	Blue Shield of California Program Management Office/Extension of Benefits 4203 Town Center Blvd. El Dorado Hills, CA 95762-9806	(800) 431-2809

To get additional copies of forms, go to [blueshieldca.com/employer/forms-resources/download-forms](https://blueshieldca.com/employer/forms-resources/download-forms) to view, save, and print any form.

# Blue Shield sales offices

## Northern California

### **Fresno**

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

### **Sacramento**

11249 Gold Country Blvd., Suite 160  
Gold River, CA 95670  
Phone: (916) 851-3400  
Fax: (916) 851-3450

### **San Francisco**

50 Beale St.  
San Francisco, CA 94105  
Phone: (415) 229-5497  
Fax: (415) 229-6230

### **San Jose**

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

### **Walnut Creek**

2175 N. California Blvd., Suite 250  
Walnut Creek, CA 94596  
Phone: (925) 927-7400  
Fax: (925) 927-7410

## Southern California

### **Los Angeles**

100 N. Sepulveda Blvd.  
El Segundo, CA 90245  
Phone: (310) 744-2583  
Fax: (310) 744-2680

### **Ontario**

3401 CentreLake Drive, Suite 400  
Ontario, CA 91761  
Phone: (909) 974-5200  
Fax: (909) 974-5220

### **Costa Mesa**

555 Anton Blvd., 8<sup>th</sup> Floor  
Costa Mesa, CA 92626  
Toll-free: (800) 965-7587  
Phone: (714) 428-4800  
Fax: (714) 428-4955

### **San Diego**

2275 Rio Bonito Way, Suite 250  
San Diego, CA 92108  
Phone: (619) 686-4200  
Fax: (619) 686-4250

### **Woodland Hills**

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





