Blue Shield of California
Blue Shield of California Life & Health Insurance Company
Small Group Underwriting Guidelines for Producers

Effective January 1, 2011
Groups of 2 to 50 eligible employees

This booklet contains guidelines that represent Blue Shield’s general approach to underwriting new and existing small group business. We will make every effort to keep you informed and up-to-date on changes to these guidelines.

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

The Active Choice® plans, Shield SavingsSM 1800/3600†, Shield Savings 2000/4000†, Shield Spectrum PPOSM Plan 2000 Value†, Shield Savings 2500, Shield Savings 3000/6000, Shield Savings 4800, Shield Savings QS 4800 Plan†, Shield Spectrum PPO Plan 3000, Shield Spectrum PPO Plan 500 Standard, Shield Spectrum PPO Plan 500 Value, Shield Spectrum PPO Plan 750 Value†, Shield Spectrum PPO Plan 1000 Value†, and Shield Spectrum PPO Plan 1500 Value† are underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

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

† Pending regulatory approval.
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Section I: General Requirements
To qualify for any Blue Shield health plan coverage on a guaranteed issue basis, a group must meet the criteria outlined below in the “Guaranteed issue,” “Employer eligibility requirements,” and “Enrollment eligibility criteria” sections.

Guaranteed issue (applies to medical only)
If the employer employs 2 to 50 eligible employees and meets the requirements of AB 1672, the employer is eligible for Blue Shield’s guaranteed issue and guaranteed renewable small group health plans. The primary requirements are:

- The employer is a California “small employer” (as defined below), actively involved in business or service, which meets the following:
  - Employed 2 to 50 permanent full-time eligible employees on at least 50% of its working days during the preceding calendar quarter or calendar year. In determining whether to apply the preceding calendar quarter or year test, Blue Shield will use the test that ensures eligibility.
  - Was not formed primarily for the purpose of obtaining health coverage.
  - The employer offers health plan coverage to 100% of its eligible employees.
  - At least 51% of group’s full-time employees must be employed in California.

Non-guaranteed issue
The following groups are not eligible for guaranteed issue, but could be considered with underwriting approval or exception:

- Groups that fail to meet the above guaranteed issue criteria.
- Carve-out groups (see Section II, “Other Requirements” page 10).
- Groups that employed fewer than two employees or no more than 50 employees on at least 50% of its working days during both the previous calendar quarter and the previous calendar year.
- Employer groups with less than 51% of all full-time employees working in California may be considered for coverage only on a non-guaranteed issue basis if the requirements listed for carve-out groups are met (see page 12), as well as all other group and enrollment criteria. Only the employees working in California will be eligible for coverage.

Employer eligibility requirements
- Must be a person, firm, proprietary, or nonprofit corporation, partnership, public agency, or guaranteed association.
- Must have and maintain business licensure and/or appropriate state filings allowing the company to conduct business in California.
- Must be actively engaged in business or service.
- Must not have been formed primarily for the purpose of buying health plan/insurance coverage.
- Majority (51% or more) of all full-time employees must be employed in California.
- Must have at least two and no more than 50 eligible employees.
- All employees must be covered by workers’ compensation when required by law.

Ineligible categories
- Associations, multiple employer trusts, union trust plans, Taft-Hartley groups, retirees, and hour bank groups are not eligible.

Blue Shield defines these groups as follows:

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

• **Hour Bank Group** - A Taft-Hartley Welfare Fund in which eligibility under the fund is determined by a specific number of hours worked. If an employee works more hours than is needed to maintain eligibility, the employee can put all or a portion of these excess hours in the bank. If an employee works insufficient hours to maintain eligibility, the employee can draw on bank hours.

Please note that other ineligible classifications include private households, single-employee companies, employees providing contracted services (i.e., receiving 1-1099 forms for income tax purposes), leased employees or employees part of a co-employment or PEO relationship domestic help, and members of organizations (such as credit unions or fraternal order member organizations). Please see Professional Employer Organization (PEO) section on page 9 for eligibility information concerning leased employees or employees that are part of a co-employer relationship.

**Employer/employee relationship**

- A bona fide employer/employee relationship must exist.
- An employee who works a minimum of 30 hours per week is considered a full-time employee.
- An employee who works at least 20 hours, but not more than 29 hours, per week is considered a part-time employee.
- Persons compensated on a 1099 basis are not eligible.
- There can only be one employer group per group benefit agreement/policy. Multiple employer groups that meet the definition of a single group employer under AB 1672 are counted as a single employer group.

**Eligible employees**

To be eligible for coverage, an employee must:

- Work on a full-time basis in the conduct of the business of the employer, whose normal work week is at least 30 hours, and whose duties in such employment are performed at the employer’s regular places of business (subject to withholding on a W-2 form); or
- Be a sole proprietor, corporate officer, or partner of a partnership engaged on a full-time basis, at least 30 hours per week, in the employer’s regular places of business;
- Work at least 20 hours, but no more than 29 hours, per week as defined under SB 1790, in the employer’s business on a permanent, year-round basis. Have met the individual employee criteria, as defined within the SB 1790 employer option.
- Receive monetary compensation for that work by the employer;
- Be a bona fide employee of the employer;
- Have met any applicable employer-imposed eligibility waiting period; and

The following are not eligible for coverage:

- Residents of Hawaii
- Retirees
- Part-time (unless SB 1790 eligible), temporary, substitute, or seasonal employees. (Seasonal or substitute employees, defined as employees hired with a planned future termination date, are not eligible.)
- 1099 independent contractors
- Domestic help
- Employees participating in a multiple employer group
- Leased employees or employees part of a co-employment or PEO relationship. (Please see PEO section for leased employees or employees that are part of a co-employer relationship.)

**Enrollment eligibility criteria**

- The group agrees to inform its employees of the availability of coverage.
- The group must inform its employees who refuse coverage that unless they qualify for late or special enrollment, as described below, they must wait until their group’s next anniversary date to obtain coverage. (See “Late enrollees” and “Special enrollment period” on page 22. Please see also pages 22 and 23 for exceptions.)
Group participation requirements
The group must maintain the required minimum participation requirements set forth below to remain eligible (or 100% participation, if non-contributory). Groups are subject to non-renewal if participation falls below the required minimum.

- **Standard minimum participation requirements:** At least 75% of all eligible employees must enroll in the Blue Shield plan(s).
- **Program minimum participation requirements:**
  - Under the Suite Deal program, a minimum of two employees and at least 65% of all eligible employees must enroll in the Blue Shield plans in that program.
  - Under the PlanSelect program a minimum of two employees and at least 75% of all eligible employees must enroll in the Blue Shield plan(s).
- **100% contribution/participation requirements:** If the group contributes 100% of dues/premium, then 100% of eligible employees must enroll (except those waiving due to other group coverage through another employer).
- **Declining or waiving coverage:**
  - A Refusal of Coverage form (C19927) is required if refusing coverage with Blue Shield due to coverage with another carrier through the same employer. Refusals of coverage in this instance are counted towards the participation requirement.
  - A Refusal of Coverage form (C19927) is required if refusing coverage with Blue Shield due to coverage with another carrier through a different employer. Refusals of coverage in this instance are not counted towards the participation requirement.
  - If an eligible employee and spouse or domestic partner both work for the same employer, they may enroll separately as employees or one may enroll as a dependent on the other's coverage. A Refusal of Coverage form (C19927) is required in each instance:
    1. if an eligible employee enrolls as a dependent spouse or domestic partner, the form is required to refuse coverage as an employee; and
    2. if each eligible employee enrolls in their own coverage, the form is required to refuse dependent coverage as a spouse or domestic partner.

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

**Employer dues/premium contribution requirements**

- **Medical/specialty benefits:**
  - The employer must contribute either (1) a defined contribution of a minimum $100 per employee (or the cost of the total employee rates, whichever is less), or (2) a minimum of 50% of the total employee rates*.
  - The employer must agree to make the required premiums payments.
  - There is no minimum contribution requirement for dependents.
  - Payroll deduction is required if contributory.
  *The 50% contribution rule applies to all dental plans and Vision Basic plans. Vision Standard, Plus and Vision Deluxe plans require a minimum of 25% employer contribution. Voluntary vision and dental plans do not require employer contribution.

**New group eligibility/effective date**

- The eligibility date for existing employees and dependents is the group’s effective date, unless new hires have not yet satisfied their group’s imposed waiting period. The effective date for these employees will be the first of the month following completion of the waiting period and submission of the small group employee application.
- Group effective dates other than the first of the month will be considered if requested to bridge coverage from the previous carrier.
- Once rates are quoted to the employer group, the employer then has 30 days in which to accept coverage at the quoted rates. Once accepted, the employer can opt to change Blue Shield plan contracts to a different plan of benefits during the first 30 days after the group’s effective date.
- However, once quoted rates are accepted by a group, the group cannot cancel coverage without being considered a cancelled or terminated group.
- Groups terminating coverage are not eligible to be considered for guaranteed coverage again within the next 12 months.
- The employer has the option, at the initial group enrollment only, to waive the waiting period for all new hires.
- Groups will not be guaranteed an effective date unless complete and correct group enrollment materials are received and approved by the underwriter.
Waiting period

- Groups may impose separate eligibility waiting periods of their own. This waiting period must be the same for each employee classification.
- The waiting period may be waived for all employees for the initial group enrollment.
- The employer has the option of choosing a first day of the month following the date of hire or a one-, two-, three-, four-, five-, or six-month waiting period for all future employees. The eligibility date for coverage for future employees is always the first day of the month following completion of the waiting period.

Eligible dependents

**Dependent coverage is available to the following individuals:**

- An employee’s legally married spouse who is not covered for benefits as an employee, and is not legally separated from the employee.
- Domestic partner who is not covered for benefits as an employee.
- An employee’s spouse’s, or domestic partner’s child (including any stepchild or child placed for adoption or any other child for whom the employee or domestic partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction) who is not covered for benefits as a subscriber, and who is less than 26 years of age.
- Enrollment requests for an adopted child or a child placed for adoption must be accompanied by confirming official adoption documents, such as court documents, or evidence of the subscriber’s or spouse’s right to control the health care of the child placed for adoption.
- A newborn child, if added to an existing policy within 31 days following the date of birth. No health questionnaire is required. Late enrollees may be subject to a 12-month waiting period.

Domestic partners

Domestic partner eligibility is a mandated benefit for all Blue Shield group health plans. To qualify as a “dependent,” a domestic partner must have filed a Declaration of Domestic Partnership with the state.

Blue Shield’s standard or portfolio small group plans include domestic partner coverage only for those domestic partners registered with the state. Some of Blue Shield’s internal documents refer to this coverage as “narrow coverage” because state registration is limited to same-sex domestic partners and only those opposite-sex couples where one partner is at least age 62 and eligible for Social Security. However, Blue Shield will offer small groups the option to select “broad coverage. The “broad coverage” defines domestic partners of either the same or opposite sex (over the age of 18). If a group selects this coverage, Blue Shield will issue an EOC/COI supplement to amend portfolio coverage.

**Domestic partner documentation requirements to enroll a domestic partner**

Although narrow coverage requires the domestic partner couple to be registered, Blue Shield will not require a copy of the California State Declaration of Domestic Partnership registration or a copy of any other municipality or county registration form or affidavit for enrollment purposes. Enrollment forms and procedures for domestic partners during initial and open enrollment periods, and during the year when a partnership is established, are exactly the same as those used by spouses. Employers have the option to request these documents, but they do not need to be submitted to Blue Shield.

**Additional Enrollment and Plan Criteria**

**HMO service area**

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

*These conditions apply to dental HMO plans as well. Dental HMO service areas are different than medical
Access Baja HMO plans

- Access Baja® HMO plans will only be offered alongside another Blue Shield health plan, such as Access+ HMO, Active Choice, Shield Spectrum PPO, Shield Savings, or Added Advantage POS plans.
- For the two Access Baja HMO plans, the employer contribution must be at least equal to the dollar contribution level of the least expensive California health plan selection, not to exceed 100% of the Access Baja plan dues.
- Access Baja HMO plans can only be offered to employees and dependents who reside or work in the Access Baja HMO service area.
- Dental, vision, chiropractic, and life insurance coverage is not available with Access Baja.
- Access Baja HMO may be offered alongside Dual Choice, Suite Deal plans, or PlanSelect™, and does not count as one of the plans in that program offering.
- Access Baja HMO rates will only be assigned a 1.0 RAF.

Local Access+ HMO

Local Access+ HMO® offers eight HMO plans as alternatives to our existing full network HMO plans. The Local Access+ network features an exclusive network of physicians available in portions of Orange, Los Angeles, San Diego, San Bernardino, Riverside, San Mateo, Sacramento, Kern, and Ventura counties, as well as all of San Luis Obispo, Santa Clara, Santa Cruz, and Yolo counties.

- Only groups located in the Local Access+ HMO service area can select the Local Access+ HMO plans.
- Groups cannot offer both the Local Access+ HMO plans and the full network HMO plans.
- The Local Access+ plans have the same benefits as our Access+ HMO plans and are offered on a standalone basis, through Dual Choice, as part of our Suite Deal package, or as part of PlanSelect™ as long as no full network HMO or POS plans are offered.

Blue Shield Plans that can be used with wrap products

- The Shield Savings 2250/4500, Shield Savings 1800/3600, and the Shield Spectrum PPO 3000 are the only plans that may be used in conjunction with any employer-sponsored wrap plan other than a health savings account (HSA) or employee-funded general purpose flexible spending account (FSA).
- Underwriting criteria prohibits pairing any other Blue Shield plan with any form of employer-sponsored wrap plans (except HSAs or employee-funded general purpose FSAs). Blue Shield may cancel the group contract/policy if such arrangement exists at any time while coverage is in place.
- An employer-sponsored wrap plan includes any employer-sponsored plan which is (1) paid for or funded in whole or in part by the employer and/or the employee; and (2) (a) provides reimbursement for health plan deductibles, copayments, coinsurance, or medical expenses, or (b) provides for the payment of set amounts in the event of hospitalization.
- Examples of an employer-sponsored wrap plan include: an employer-funded flexible spending account (FSA), a health reimbursement account (HRA), self-funding of the deductible, an IRS Section 105 plan, a medical expense reimbursement plan (MERP), or a hospital confinement policy. It does not include a health savings account (HSA) or general purpose flexible spending account (FSA).
- A Verification and Statement of Understanding form (C20283) is required for all new groups. The form must be signed by both the producer and a representative of the group without alteration.

Additional benefits available

- Inpatient substance abuse optional benefit
- Infertility optional benefit
- Dental contract (underwritten by Blue Shield of California)
- Blue Shield Life Vision Basic
- Blue Shield Life Vision Basic, Standard, Plus, or Deluxe policy (available to groups of two or more eligible employees)
- Life group term life and AD&D policy available with or without a health plan*

*Group term life Insurance for groups with 2 to 9 eligible employees is administered and underwritten through a small group employer trust.
Dual Choice
Groups of two or more eligible employees can pair any one Access+ HMO plan with a Shield Spectrum PPO, Shield Savings or Active Choice plan for a Dual Choice package.

- Access Baja HMO may be offered in addition to a Dual Choice package.
- Blue Shield’s minimum 75% participation requirements apply.
* Underwritten by Blue Shield of California Life & Health Insurance Company

PlanSelect
PlanSelect is a multiple plan offering for employer groups with 2 to 50 enrolled employees. Employers with 2 to 50 enrolled employees can choose up to 35 plans, except for Access Baja HMO plans and Shield Spectrum PPO-XCC plans. In addition, Local Access+ HMO plans may not be offered alongside any full network HMO or POS plans.

Employer dues/premium contribution options
Employers can select a defined dues/premium contribution amount. A minimum of $100 per enrolled employee or 50% of the total employee dues/premium.

Participation requirements:
- Under the PlanSelect program a minimum of two employees and at least 75% of all eligible employees must enroll in the Blue Shield plan(s).
- See the Group Participation Requirements section for additional details on participation requirements.

PlanSelect notes:
- Employers whose place of business is located outside of one of Blue Shield of California’s HMO service areas will not have the option of offering an HMO plan within PlanSelect.
- When selecting PlanSelect for groups with 2 to 50 enrolled employees, employers may choose up to 35 plans on the master application to make selected plans available for future hires. When enrolling 2 to 50 employees in PlanSelect, you do not need to enroll employees in all selected plans.
- California employers in certain counties and cities whose eligible employees live and/or work in the Local Access+ HMO service area have the option of choosing a PlanSelect package with either Access+ HMO plans or Local Access+ HMO plans but not both.
- Local Access+ HMO products are available as part of the PlanSelect package provided they are the exclusive HMO plan option. Local Access+ HMO plan options may not be combined with or offered alongside any other full network HMO or POS product (except Access Baja HMO).
- Access Baja HMO plans can be offered alongside those chosen through PlanSelect, but they do not count toward PlanSelect restrictions.

PlanSelect optional benefits
Groups must purchase the same optional benefits (e.g. chiropractic optional benefits) for all plan types selected within PlanSelect. If the optional benefit is not available on one of the plan types selected, it cannot be offered for the other like plan types selected by the group.

Suite Deal program

- Under the Suite Deal program, a minimum of two employees and at least 65% of all eligible employees must enroll in the Blue Shield plans in that program. This reduced participation requirement is only available for groups that enroll under the Suite Deal program.
- See the Group Participation Requirements section for additional details on participation requirements.
- Employers in certain California counties and cities whose eligible employees live or work in the Local Access+ HMO service area have the option of choosing the Suite Deal medical plan package with either the Access+ HMO plans or the Local Access+ HMO plans but not both.
- All plans in the Suite Deal must be offered, however enrollment in all plans is not required.
- With the exception of Access Baja, additional Blue Shield plans cannot be selected.

1 The employer must be located, and all enrolled employees and eligible family members must live or work, in an approved Blue Shield of California HMO/POS service area in order to be eligible to purchase HMO/POS health plans.
2 Underwritten by Blue Shield of California Life & Health Insurance Company.
Suite Deal optional benefits

Groups must purchase the same optional benefits (e.g. chiropractic optional benefits) for all plan types selected within Suite Deal. If the optional benefit is not available on one of the plan types selected, it cannot be offered for the other like plan types selected by the group.

Section II: Other Requirements

Groups with union and non-union employees

If an employer has union and non-union employees but is only offering coverage to the non-union employees and the union employees do not have access to health coverage through a union trust fund, standard carve-out underwriting guidelines will apply.

If an employer has union and non-union employees and the union members can receive health coverage through trust fund established by a collective bargaining agreement, Blue Shield has special arrangements available as follows to cover only the non-union employees:

Small employer groups

If the total number of both union and non-union eligible employees does not exceed 50, the employer can apply for small group coverage on a guaranteed issue basis to cover only the non-union employees. Only the eligible non-union employees will be counted for purposes of minimum enrollment and participation requirements. To qualify for this coverage, the employer must provide Blue Shield with:

- A copy of the collective bargaining agreement showing that the employer pays contributions to the trust fund.
- The Statement of ERISA Rights from the union trust fund Summary Plan Description.

Professional Employer Organization ("leased") employees

Professional Employer Organization ("PEO" or "leased") employees are considered employees of the PEO Company. Small employer groups that have canceled their PEO arrangement and hired the former PEO employees will be considered for coverage on a guaranteed issue basis pursuant to Small Group rules. Groups obtaining employees through a PEO may apply for non-guaranteed issue coverage.

- If any employee of the small employer group had coverage through the PEO with Blue Shield of California, the small employer group will not be eligible for guaranteed issue coverage from Blue Shield of California for 12 months from the date of disenrollment from the plan contract through the PEO.
- If any employee of the small employer group had coverage through the PEO with Blue Shield of California Life & Health Insurance Company (Blue Shield Life), the small employer group will not be eligible for guaranteed issue coverage from Blue Shield for 12 months from the date of disenrollment from the policy through the PEO.

Guaranteed Issue coverage - For small employer groups that have recently canceled their contract with a PEO:

- A copy of the letter sent from the PEO to the client business verifying the cancellation of the leasing arrangement will be required.
- If a copy of a payroll register from the PEO Company is submitted with the new group application that separates the formerly leased employees by business location, the group will be considered a guaranteed issue group.
**Non-Guaranteed Issue coverage** - For small employer groups with an existing PEO contract for employees:

- A group that has an active agreement under a PEO with current leased employees is not a small employer and will only be considered for coverage on a non-guaranteed issue basis.

- Normal contribution and participation requirements must be met. The employees must work solely for the employer group.

- A payroll register from the PEO that lists all the employees working at the group’s place of business is required. The payroll register must include the name of the subgroup company; employee names; Social Security numbers; current wages for the pay period; withholdings; and the year-to-date totals for the wages and withholdings.

- Health statements are required.

**Combining multiple employer groups**

If an owner believes that the structure of his/her holdings produces a single employer/employee relationship, Blue Shield will require copies of all associated Articles of Incorporation, Partnership Agreements, and a letter from the employer’s CPA stating that all business entities are eligible to file a combined tax return. Blue Shield’s determination of whether or not there is one responsible employer will be final.

**Spin-off groups**

A “spin-off group” is a newly formed business that is not yet eligible for guaranteed issue, and in which a majority of the employees of the new business have left an established business (“former business”) currently offering Blue Shield coverage to its employees.

Spin-off groups will be issued coverage through underwriting. Please note that a spin-off group is not subject to small group RAF restrictions.

The requirements for issuance of coverage are:

- At least 50% of the employees in the spin-off group must have been enrolled in Blue Shield through the former business.
- All enrollment documents are required (master application, subscriber applications, refusals, business check, etc.)
- Completed health statements are required.
- Ownership paperwork and eligibility verification for the owner is required.
- A copy of the most recent payroll register is required. If no payroll register is available, a W-4 form for all employees will be initially required, with subsequent submission of the first complete payroll register within 30 days of the group’s effective date.

**Carve-out groups**

The Affordable Care Act (ACA) includes a provision that prohibits employer groups with fully-insured health plans from offering discriminatory coverage to its employees, officers, and shareholders. This means that highly compensated individuals in the company cannot be offered coverage that is not available to a significant number of the other employees.

- Highly compensated Individuals are defined as the five highest paid company officers, 10% or greater shareholders, and the highest paid 25% of all employees.
- It is the responsibility of the employer group to identify whether or not they have a non-discriminatory plan,
- Blue Shield will not sell coverage that is limited to highly compensated individuals in the company.

Small (2 to 50 eligible employees) and midsize (51 to 299 eligible employees) employer groups that wish to limit enrollment to a specified group of employees (“carve-out groups”) that is not based on compensation can be considered for coverage on a non-guaranteed issue basis. These groups will have guaranteed renewability and must meet the following additional requirements:

**Employer groups of 2 to 50**

- Group is qualified as a small employer under AB 1672.
- Employee Health Statements are required for carve-out groups (see union versus non-union for exceptions).
- Carve-out groups may include for underwriting consideration:
  - Salaried versus hourly wage earners (as long as this does not result in the limitation of coverage to highly compensated employees as defined in ACA).
  - Specific office location.
  - California only employees when the group is located outside California.
  - Union versus non-union when the union employees do not have access to health coverage through a union trust fund.
- A minimum of eight enrolling employees is required.
• A clear definition of the carve-out classification that the employer wishes to cover will be required.
• Blue Shield must be the employer's only carrier for the carve-out group.
• Carve-out groups are subject to underwriting approval, and may be declined if they do not meet Blue Shield’s underwriting criteria.

Employer groups of 51 to 299
• Moratorium industries will not be considered for coverage. (See page 23 for list of industries.)
• A minimum of eight enrolling employees is required.
• Employee Health Statements are required for all carve-out groups.
• Carve-out groups may include for underwriting consideration:
  - Salaried versus hourly wage earners (as long as this does not result in the limitation of coverage to highly compensated employees as defined in ACA)
  - Specific office location
  - California only employees when the group is located outside California
  - Union versus non-union
• A clear definition of the carve-out classification that the employer wishes to cover will be required.
• Blue Shield must be the employer's only carrier for the carved-out class of employees.
• Carve-out groups are subject to underwriting approval, and may be declined if they do not meet Blue Shield’s underwriting criteria.

NOTE: Small employer group plans are available to employer groups of 51-299 eligible employees, but Blue Shield is not obligated to follow the requirements of AB 1672 (Cal. Health & Safety Code Section 1357) with respect to such groups.

Part-time employee (PTE) coverage
All guidelines that apply to full-time employees also apply to PTE’s with these additional guidelines:
• The PTE must work a minimum of 20 hours per week to be eligible. The employee must have worked at least 20 hours, but not more than 29 hours, per normal work week, for at least 50% of the working days in the previous calendar quarter.
• It is the employer’s option to offer health coverage to PTEs. If that option is exercised, all similarly situated individuals must be offered coverage under the employer’s benefit plan.
• The employer contribution, waiting period and benefit choice (which may include dental) must match the coverage given to full-time employees.
• Participation requirements and group size are based on the total number of PTEs and FTEs.
• To add PTE eligibility to an existing account, we require a cover letter, a new employer application, a DE-6 and applications/declinations on all eligible PTEs.
• Existing groups may only add this option on their renewal date.
• Blue Shield may require information necessary to document the hours and time periods of PTEs, including, but not limited to, payroll records and employee wage and tax filings.

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

Section III: Rating Criteria
Quoting a group
Field rating
A field-rating tool is available to producers, to allow quick and easy online rating for groups of 2 to 50 eligible employees. The rating tool is available at blueshieldca.com/producer.

Rating process
• Non-guaranteed issue – Complete Employee Health Statements are required for all non-guaranteed issue groups regardless of size.
• Guaranteed issue:
  - Guaranteed issue groups enrolling 2 to 14 employees are not required to submit a completed Employer Questionnaire. Employee Health Statements are required. Groups enrolling 2-5 employees may apply for an automatic RAF of 1.10 without completing individual health statements or may submit health statements to request a lower RAF through underwriting.
  - Guaranteed issue groups enrolling 15 or more employees are required to submit a completed Employer Questionnaire. Individual Health Statements are not required. See Section VIII, “Industry and COBRA Loads” on page 24 for a description of how a RAF is assigned based on information provided in the Employer Questionnaire.
• The RAF is based on the information provided by the group; however, should any enrolling employee have prior Blue Shield coverage, prior claims history may be reviewed and may affect the final RAF.

• Workers’ compensation coverage is required by law. The absence of workers’ compensation coverage may also affect the final RAF.

• For groups of 2 to 50 enrolled employees, that qualify for guaranteed issue, the Risk Adjustment Factor (RAF) range is 0.90 to 1.10, subject to the following underwriting guidelines:
  - For groups of 2 to 5 enrolled employees, the lowest RAF is 1.00.
  - For groups of 6 to 9 enrolled employees, the lowest RAF is 0.95.
  - For groups of 10 to 50 enrolled employees, the lowest RAF is 0.90.
  - Specialty benefits product rates are not subject to a RAF.

• For groups that do not qualify for guaranteed issue, underwriting will determine the RAF. Complete Employee Health Statements are required. Employee Health Statements are used to establish the applicable RAF. The RAF assigned can exceed 1.10 or the group may be declined.

• Small group Rate Tables list rates for the most common RAFs. The tables offer quick access to our rates without having to use the field-rating program.

• Access Baja HMO rates are not subject to RAF.

• Group monthly premiums are calculated based on the subscribers’ ages and the employer’s ZIP code as of the first day of the month.

• Each employee’s and his or her dependents’ rates will change the month after the employee reaches the new age band. Billings will automatically reflect the new rate.

• Composite rating is not available.

• Before submitting an application for a group, please review the requirements under “Submitting an application” and “Certifying your compliance” on page 26.

Rating policies

• All rates will be based upon actual enrollment.

• Final rates, effective date, and acceptability of the group will be determined by the small group underwriter.

• Approved out-of-state employees will be charged an area rate based on the location of the employer’s California place of business.

Medicare primary and secondary rating guidelines

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

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

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

Medicare is the primary coverage and the employer’s group health plan is secondary for employees with Medicare Parts A and B in firms with fewer than 20 employees. This can qualify a group for a reduced premium rate from their health plan for medical benefits; Blue Shield of California chooses to offer this reduced rate to our clients to help mitigate the cost of coverage.

Groups will be required to supply Blue Shield with validation of small group status at each renewal to continue to qualify for the reduced rates for their Medicare eligible employees.

Please note: If copies of the group’s DE-6’s are not received within 30 days of their renewal effective date, they will not receive the reduced rate for these employees for the renewal year. For employees with Medicare Parts A and B that are not currently receiving the reduced rates, employers must submit a copy of the employee’s Medicare card in addition to the DE-6’s.

2. Medicare entitlement based on disability

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

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

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

More complex situations (such as Medicare dual entitlement) do arise. If you have any questions concerning Medicare entitlement for groups offering Blue Shield commercial plans, please contact Blue Shield for further guidance.

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

Rate changes for guaranteed issue groups
The group’s RAF will not change more often than every 12 months (Blue Shield renews most groups on their anniversary date). The maximum change in RAF is 10 percentage points, in addition to any increases that may have been made to the base (1.0) rate.

Rate changes for non-guaranteed issue groups
The group’s RAF will not change more often than every 12 months; however changes in RAF may exceed 10 percentage points and may be less than .90 or greater than 1.1.

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

1. The employer does not pay the required premium.
2. The employer does not contribute toward employee premium.
3. The small employer commits any act of fraud or misrepresentation.
4. The group’s eligibility drops below the required minimum of two employees in which case the group will be cancelled at its anniversary date.
5. The employer moves outside of the Blue Shield of California-approved service area.
6. The group does not continue to meet participation and contribution requirements.

Cancellation of coverage may be retroactive to the first date upon which any of the above reasons took effect.

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

Section IV: New Business Submission Requirements

Guidelines for completing forms
To ensure fast and accurate application processing, follow these guidelines for AB 1672 (small employers as defined by Cal. Health & Safety. Code §1357).

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

For new group submissions, the employee’s signature cannot be dated more than 45 days prior to the requested effective date. All answers on the Health Statements (if applicable) and enrollment applications must be in the employee’s own handwriting.

- On the original employee application, no alterations or changes may be made by anyone other than the employees. Any changes to a health question answer on the small group enrollment application must be initialed and dated by the applicant.
- Language assistance: Whenever an individual(s) completing the application(s) has a language barrier and requires assistance to properly complete the form, a signed Blue Shield Exception to Standard Enrollment Form from the group or the producer explaining the situation must accompany the submitted application.
Processing time specifications

- Because processing applications within specific time frames is important, all forms and other documents for evaluation should be accurately completed and included with the application when the case is first submitted to Blue Shield.

- The underwriting department can usually make a timely decision if all proper documentation is received with the initial submission. Please refer to the “Group enrollment checklist” on page 14 for a list of required documentation. Any missing documentation and/or dues will cause a delay in the underwriting process. Underwriting will only request additional information when it is needed to accurately assess or verify the eligibility of the group and/or employee(s).

- Blue Shield must receive all completed paperwork by the fifth working day of the month when the requested effective date is for the first day of that month. Any additional required information must be submitted to Blue Shield within 48 hours of the request, to complete the processing within that month. Under most circumstances, the underwriting department will not request an attending physician’s records. However, additional medical information is sometimes required to determine the appropriate risk adjustment factor. You can obtain a preliminary review from the underwriting department by submitting a completed Probable Action Request form for groups of 5 to 14 enrolling employees, or an Employer Questionnaire form for groups with 15+ enrolling employees. Blue Shield will examine the group to determine its eligibility and the probable risk adjustment factor. This is only a preliminary review and any estimated RAF is not binding on Blue Shield. The final and binding underwriting decision will be made when all required documents have been received and evaluated.

- The payroll submitted must be copies of each payroll register for each pay period covered. Individual payroll/pay stubs, estimated payroll, payroll summaries, or handwritten journals are not acceptable.

Evaluation criteria

Underwriting is based on the following criteria:

- Contribution
- Health
- Employee and dependent eligibility
- Participation
- Group demographics
- Employee turnover
- Workers compensation
- SIC codes

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

Blue Shield may decline groups if:

- No bona fide employer/employee relationship exists (i.e., independent contractors; leased employees; domestic help).
- Group has more than 49% of employees located outside California.
- Employer is not authorized to conduct business in California.
- Group employed less than two or more than 50 employees on 50% of the workdays in the previous calendar quarter or the previous calendar year.
- Group terminated prior Blue Shield coverage less than 12 months prior to application for small group coverage.
- Group is a carve-out (see Section II, “Other Requirements”).
- Group is otherwise not subject to AB 1672 guidelines.

Group enrollment checklist

The following are required documentation when submitting new business:

- Master Group Application
- Applications from all enrolling employees and dependents
- Refusal of Personal Coverage forms for all eligible employees and any eligible
dependents that refuse or waive coverage at the time of open enrollment.

- **Verification and Statement of Understanding form**
- **Health Statements** are required for guaranteed issue groups of 2 to 14 enrolling employees and all carve-out and non-guaranteed issue groups. All Health Statements must be dated within 45 days of the requested effective date. Groups enrolling 2-5 employees may apply for an automatic RAF assignment of 1.10 without completing health statements or may submit health statements to request a lower RAF through underwriting.
- **Binder check** on company check stock

Additional documentation may be required under certain circumstances:

- **Employer Questionnaires** are required for guaranteed issue groups of 15 to 50 enrolling employees. The Employer Questionnaire must be dated within 45 days of the requested effective date. **For eligibility verification, the following wage information is required for each enrolling employee:**
  - Copy of the group’s most recent DE-6 Quarterly State Tax Withholding Statement containing current employment status of all employees.*
  - All four DE-6s from the previous year if group eligibility is based on, or includes, part-time employees.
  - Two DE-6s from the previous calendar year if group indicates they are impacted by the Federal Mental Health Parity and Addiction Equity Act (HR 1424).
  - Payroll records for employees hired after the DE-6 filing.
  - Proof of owner/employer’s eligibility if the owner/employer is not listed on the DE-6.
  - Groups enrolling 2 to 24, same as noted in “Owner only groups” below.
  - Groups enrolling 25+ Blue Shield of California Sole Proprietor, Partner, or Corporate Officer Statement (owner affidavit).
  - If applying for small group replacement coverage, a copy of the last month’s group premium statement.
  - If applying for continuous replacement coverage, documentation of the previous coverage with the last premium statement.
  - Disability Form (if applicable).
  - COBRA/FMLA/Cal-COBRA Election Form, if applicable.
  - A business check for the first month’s dues as a deposit, payable to Blue Shield of California or Blue Shield Life as applicable.

Blue Shield will refund the full deposit to the group if the group application is declined.

- A copy of the most recent payroll register is required for new employees hired after the DE6 filing.

**Owner-only groups** are required to submit documentation verifying that they are active businesses. That documentation includes but is not limited to:

- Sole Proprietorship: 1040 Schedule C for the preceding calendar year and a completed Blue Shield of California Sole Proprietor, Partner, or Corporate Officer Statement.
- Partnership: K-1 for the preceding year for each partner and a completed Blue Shield of California Sole Proprietor, Partner, or Corporate Officer Statement.
- Corporation: Articles of Incorporation (state seal affixed) to include the filed list of officers:
  - K-1 and a completed Blue Shield of California Sole Proprietor, Partner, or Corporate Officer Statement.
  - Signed enrollment form or refusal for each officer eligible for coverage.
### Documentation to submit, based on nature of business

<table>
<thead>
<tr>
<th>Number of Enrolling Employees</th>
<th>Sole Proprietor</th>
<th>Partnership/ Limited Partnership (LP)</th>
<th>Corporations</th>
<th>Limited Liability Company (LLC)</th>
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</thead>
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<tr>
<td><strong>Owners Only</strong></td>
<td></td>
<td>Business license or Fictitious Business Name Filing</td>
<td>Partnership Agreement or Business License or Fictitious Business Name Filing</td>
<td>Owner Affidavit</td>
</tr>
<tr>
<td></td>
<td>Owner Affidavit</td>
<td>Signed Enrollment Application or Refusal of Coverage</td>
<td>Binder check on company check stock</td>
<td>Recent Schedule C۱</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Binder check on company check stock</td>
<td>Recent K-1۱</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>DE-6۳ or 6 weeks of payroll۳</td>
<td>If owners not listed on DE-6:</td>
<td>Recent Schedule C۱</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DE-6۳ or 6 weeks of payroll۳</td>
<td>If owners not listed on DE-6:</td>
<td></td>
</tr>
<tr>
<td><strong>2 to 5</strong></td>
<td>Business license or Fictitious Business Name Filing</td>
<td>Partnership Agreement or Business License or Fictitious Business Name Filing</td>
<td>Articles of Inc. or Statement of Information</td>
<td>Owner Affidavit</td>
</tr>
<tr>
<td></td>
<td>Owner Affidavit</td>
<td>Signed Enrollment Application or Refusal of Coverage</td>
<td>Binder check on company check stock</td>
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<tr>
<td></td>
<td>Signed Enrollment Application or Refusal of Coverage for all eligible employees</td>
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<td>Recent Schedule C۱</td>
<td>Recent K-1۱</td>
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</tbody>
</table>

1 Business license or Fictitious Business Name Filing
2 Articles of Inc. or Statement of Information
3 DE-6 or 6 weeks of payroll
4 Recent Schedule C or K-1

Businesses established out of state require a Cert. of Qualification or Statement by Foreign Corporations
Businesses established out of state require a Foreign LLC Application for Registration
### 6 to 24

<table>
<thead>
<tr>
<th>Business License or Fictitious Business Name Filing</th>
<th>Partnership Agreement or Business License or Fictitious Business Name Filing</th>
<th>Articles of Inc. or Statement of Information</th>
<th>Statement of Organization with Operating Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signed Enrollment Application or Refusal of Coverage for all eligible employees</td>
<td>Signed Enrollment Application or Refusal of Coverage for all eligible employees</td>
<td>Signed Enrollment Application or Refusal of Coverage for all eligible employees</td>
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<tr>
<td>If owners not listed on DE-6: Owner Affidavit</td>
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<td>Businesses established out of state require a Foreign LLC Application for Registration</td>
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</table>

### 25+

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<th>Signed Enrollment Application or Refusal of Coverage for all eligible employees</th>
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</table>

1. Proof of income for owners is required, such as cancelled draw checks, if tax filings are not available due to length of time in business or a tax filing extension.
2. A copy of the most recent payroll register is required for new employees hired after the DE6 filing.
3. Six weeks of payroll records are required for businesses that have been in business for at least six weeks prior to the requested effective date but not long enough to have a filed DE6. Payroll records must be for at least two eligible employees.

**Note:** Blue Shield’s underwriting department may request additional documentation in situations where an affidavit was submitted but eligibility questions remain. Articles of Inc., Statement of Information, and Statement by Foreign Corporation, must be filed and stamped listing names of all officers/owners.
Waivers/declinations

- If an employee is waiving coverage due to group coverage (either as a subscriber or a dependent), the employee may be considered ineligible for the purposes of calculating participation. The employer group must submit a declination form for these employees.

- Any eligible employee and/or dependent waiving coverage for any reason at the time of enrollment, or canceling coverage for themselves or dependents for any reason, must complete the Refusal of Personal Coverage section on the back page of the Employee Application form, and the employer must forward this information to Blue Shield.

- For employers offering more than one carrier, waivers are required for employees that are enrolling in another carrier’s plan.

Spouses or domestic partners working for the same employer

If spouses or domestic partners both work for the same employer, they may enroll separately as employees or one may enroll as a dependent on the other’s coverage.

A Refusal of Coverage form (C19927) is required in each instance:

1) If an eligible employee enrolls as a dependent spouse or domestic partner, the form is required to refuse coverage as an employee; and

2) If each eligible employee enrolls in their own coverage, the form is required to refuse dependent coverage as a spouse or domestic partner.

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

Groups that also choose a Blue Shield specialty benefits plan

Only one binder check is required for the total first month’s medical and specialty benefits plan dues. Simply note the portion applicable to the specialty benefits dues on the check. Blue Shield will refund the full deposit to the group if the group application is declined.

Section V: Existing Business Guidelines

Enrolling new hires

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

- Effective dates are determined as follows:

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

b) If the application is received by Blue Shield after the eligibility date, but within 31 days of becoming eligible, the effective date becomes the first day of the month following approval by Blue Shield.

c) If the application is received by Blue Shield more than 31 days after the employees’ eligibility date, the applicant is considered a late enrollee and the effective date may be delayed by up to one year from the date of application for enrollment.

- For coverage declination, the Refusal of Personal Coverage section on the back page of the Employee Application form must be completed any time an employee and/or dependent becomes eligible but does not enroll, or if the employee and/or dependent remains eligible, but is not retaining coverage.

- Dependent special enrollment periods are provided for newborns, adoptees and new spouses/domestic partners. These dependents may be added without a waiting period if they are enrolled within 31 days of becoming eligible. In addition, spouses/domestic partners who are eligible (but not enrolled) may also be added in the event of a birth or adoption. An employee who is eligible (but not enrolled) may enroll at the time of marriage/establishment of a domestic partnership, birth, adoption, or placement for adoption.

Enrolling late enrollees

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

An eligible employee or dependent who refused their employer’s health plan coverage when they were first eligible to enroll because they were enrolled in another employer’s health benefit plan, and who requests enrollment after a loss of coverage under that other employer’s health benefit plan and under certain conditions as set forth in the definition of “late enrollee” under Section VII, is not considered a “late enrollee.” Such an employee or dependent must request enrollment within 31 days after his or her loss of that coverage, and must also submit verification of that coverage. If enrollment is not requested within 31 days, the employee or dependent is subject to “late enrollee” requirements.
Special enrollment period
There is a special enrollment period for eligible employees who refused their employer's health plan coverage when they were first eligible to enroll, but for whom one of the following events then occurs:

- The employee marries/establishes a domestic partnership;
- The employee has a baby; or
- The employee adopts a child, a child is placed for adoption with the employee, or the employee becomes the court-appointed legal guardian of the child.

In these situations, the employee who initially refused coverage and the employee's newly acquired spouse or dependent child are eligible to request enrollment within 31 days of one of the above events occurring. Dependent spouses and children cannot be enrolled prior to (or without) the employee being enrolled.

NOTE: If an unenrolled employee acquires a new dependent through birth, adoption, or legal guardianship, the employee can enroll all other eligible dependents, including the spouse/domestic partner, as of the qualifying event date.

If the employee requests enrollment within 31 days, coverage for the employee and the newly acquired spouse or dependent coverage will be effective:

- For the employee and his or her newly acquired spouse/domestic partner: the first day of the month following the receipt of request for enrollment;
- For the employee and his or her newly acquired baby: on the date of baby's birth;
- For the employee and his or her newly acquired child: on the date that the employee has the legal right to control the adopted child’s health care.

Please note that any applicable pre-existing condition exclusion will apply to the employee and his or her newly acquired spouse/domestic partner, but not to the newly acquired baby or adopted child.

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

During the open enrollment period, employees currently enrolled in or Dual Choice groups may transfer into any available employer-sponsored health plan, including PlanSelect.

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

Guaranteed renewal
A group with an existing Blue Shield Group Health Service Contract is eligible for guaranteed renewal if:

- It is a group of two or more employees;
- It has made all required premium payments;
- Neither it nor its employees or dependents have committed fraud or misrepresentation;
- Maintains the required 51% of its employees in California;
- It continues to meet participation and contribution requirements; and
- It has otherwise maintained guaranteed issue eligibility.

A group is not eligible for guaranteed renewal if:
- It does not meet all of the conditions above, or:
- The group moves out of the service area; or
- Its association membership through which it obtained Blue Shield plan coverage ceases.

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

Blue Shield reserves the right to change the group’s RAF at renewal (subject to the rate increase limitations specified in AB 1672). Blue Shield also reserves the right to obtain documents at each renewal to re-certify that the group is an eligible small employer as defined in AB 1672.

Small to large group renewal conversions
Federal law now allows for a group to renew its Blue Shield small employer plan, even if the group has grown in size and is technically a large (51+ employees) employer. However, if the group decides not to renew its Blue Shield small employer plan, and instead applies for a non-guaranteed issue Blue Shield large employer plan (and is accepted by Blue Shield), the group cannot later apply for a guaranteed issue small employer plan.

Contract benefit modifications

Group level

Employer-requested health plan or contract changes can only be effective on the group’s renewal date.

Changes to add or delete specialty benefits coverage may be made during the plan year.

Depending on the type of benefit modification requested, underwriting may be required. Certain supporting documentation is also required to review a request to modify benefits. The required documentation must be complete and accurate to process the request. Please also refer to the Benefit Modification Options exhibit on page 20 to determine
when each type of benefit modification may be requested and to determine what documents must accompany your request.

Subscriber level

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

Re-enrollees

- Re-enrollees (See Section VII, “Definitions”) must complete an Employee Application Form, including the health section, and may be subject to a 12-month waiting period.

Individual conversion

- When coverage under the employer plan is cancelled, individuals may apply to Blue Shield within 63 days for a Conversion Benefit Agreement. **The terms, benefits, and subscription changes of the conversion plan are different from those of the employer plan. Please note that since enrollment into an individual conversion plan is not considered group coverage, this selection results in the loss of eligibility for enrollment into an individual GI HIPPA plan.**

Conversion membership is not available if:

  a) The member’s coverage under the employer plan ends because the subscriber fails to pay his contribution toward subscription charges, or
  b) The member is eligible for group health coverage when coverage under the employer plan ends, or
  c) The member is eligible for Medicare coverage when coverage under the employer’s plan ends, whether or not the member is actually enrolled in Medicare, or
  d) The member is covered under any individual health plan when coverage under the employer plan ends, or
  e) The member is terminated for good cause or for fraud or misrepresentation; or
  f) The member furnished incorrect information or otherwise improperly obtained the benefits of the plan.
  g) Application for Blue Shield conversion coverage is available without a Health Statement, as long as there has been no lapse in coverage and first quarterly dues, along with a completed enrollment form, are received by Blue Shield within 63 days of the subscriber’s termination.

**NOTE:** If an individual selects a conversion plan or other individual plan, they waive their right to HIPAA guaranteed issue (GI) individual coverage. To qualify for HIPAA GI coverage, an individual’s last most recent coverage must be employer sponsored.
## Benefit Modification Options Chart

<table>
<thead>
<tr>
<th>Benefit modification</th>
<th>When eligible</th>
<th>Necessary documents</th>
</tr>
</thead>
</table>
| **Add medical benefits**                                        | On group’s anniversary date | 1. Letter from group  
                                                                 |                        | 2. Subscriber Change Request form for those employees requesting to change |
| Includes:                                                      |                        |                                                                                     |
| • Increasing number of plans offered under existing Blue Shield health coverage |                        |                                                                                     |
| • Change in level of benefits offered under existing Blue Shield health coverage |                        |                                                                                     |
| **Add part-time employee eligibility**                          | On group’s anniversary date | 1. Letter from group  
                                                                 |                        | 2. DE-6  
                                                                 |                        | 3. New applications or declinations on all eligible part-time employees |
| **Select broad domestic partner coverage (any domestic partner who signs an affidavit) rather than portfolio state-registered domestic partner coverage (i.e., narrow coverage)** | On group’s anniversary date | RFA will indicate that the group has selected broad coverage.  
                                                                 |                        | Blue Shield does not require a Domestic Partnership Affidavit. The necessary documents to enroll domestic partners are the same as those used for a spouse. |
| **Change to employer waiting period**                           | On group’s anniversary date | Letter from group  
                                                                 |                        |
Section VI: Benefit Continuity

Prior deductible credit
For an employee enrolled as of the initial effective date in a Blue Shield PPO, POS, and PSP plan, Blue Shield will credit the amount of the deductible satisfied for medical expenses under the benefit plan of the employer group’s prior carrier in the same calendar year; however, there is no prior carrier deductible credit for outpatient prescription drug coverage. The employer’s prior carrier information is provided by the employer on the master group application.

Pre-existing conditions
Pre-existing condition exclusions are imposed, where applicable, for up to six months following the effective date of coverage (including the employer’s waiting period) and are applied to conditions for which care was sought or provided within six months of the enrollment date. Pre-existing illness, injuries, or conditions are those for which any medical advice, diagnosis, care, or treatment was recommended or received from a licensed practitioner. Pre-existing condition exclusions are not applicable to newborns and adoptees. Pregnancy is not subject to any pre-existing condition exclusions.

NOTE: The “look-back” period for a pre-existing condition begins with the enrollment date (usually the hire date, not the effective date).

- Blue Shield will give credit for prior medical coverage (including individual, group or state-sponsored programs) in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Cal. Health and Safety Code Section 1357.06. (Verification is required.)
- Our Access+ HMO, Access Baja HMO, and POS plans have no pre-existing condition limitations.
- Our PPO and Health Savings Account (HSA)-eligible, high-deductible health plans have a six-month pre-existing condition exclusion (with the exception of pregnancy and newborns and newly adopted children who, by law, have prior credible coverage within 30 days of the birth, adoption, or placement for adoption; and are enrolled in this group health plan within 63 days of that prior credible coverage).
- During the six months after the member’s enrollment effective date, the plan will exclude coverage for charges or expenses incurred for any condition, including total disability, for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the effective date of enrollment.
- Exception: Replacement coverage by present employer

Pre-existing conditions, except total disability are covered immediately if employees and dependents were:

- Enrolled in their existing employer’s previous group health plan when it terminated;
- Enrolled in a Blue Shield PPO health plan on its original effective date; and
- The original effective date is within 60 days of the termination of the employer’s previous group health plan.

Total disability - A total disability should be treated like any other pre-existing condition except as noted above. HIPAA requires non-discrimination based on health status. Therefore, the replacement carrier is obligated to enroll the employee if totally disabled under the prior carrier. The prior carrier is only responsible for extending benefits if 1) there is no replacement carrier or 2) the replacement carrier has a pre-existing condition exclusion and the totally disabled employee does not have six months of creditable coverage. HIPAA’s non-discrimination provision based on health status also applies to hospital-confined employees and employees not actively at work.

- If the employee is transferring to a PPO plan or HSA-eligible, high-deductible health plan from prior health coverage (medical, hospital, and surgical coverage) within the time limits specified by AB 1672 (for individual health coverage within 63 days of the group’s effective date; or for employer group coverage within 180 days of the group’s effective date), the employee will be credited the time he or she was covered under the prior health coverage towards the six-month pre-existing condition exclusion.
- New hires, re-enrollees, and late enrollees could be subject to the pre-existing clause as stated above.

Takeover provisions
Blue Shield small group takeover provisions comply with the following:

- Any carrier providing replacement health coverage within a period of 60 days from the date prior coverage is discontinued which provides comparable health coverage to the new contract, will be required to cover all employees and dependents who were both
  - 1) Validly covered under the prior contract at the time the contract was discontinued, and
  - 2) Within the definitions of eligibility under the succeeding carrier’s contract.
- Such employees and dependents will be eligible regardless of any other provision within
the succeeding carrier's contract relating to active full-time employment or pregnancy.

- However, with respect to employees or dependents who are totally disabled on the date of discontinuance of the prior contract, and eligible for an extension of benefits under that contract, the succeeding carrier is not required to provide benefits directly related to any condition which caused the total disability, except to the extent it may apply any applicable pre-existing conditions limitation (after giving credit for prior coverage as required by law).

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

Section VII: Definitions

Guaranteed associations defined

A guaranteed association is:

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

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

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

Late enrollee - Is defined as an eligible employee or dependent who has declined enrollment in a health benefit plan offered by a small employer at the time of the initial enrollment period provided under the terms of the health benefit plan, and who subsequently requests enrollment in a health plan of that small employer, provided that the initial enrollment period shall be a period of at least 30 days.

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

1. The individual meets one of the following:

   a) He or she was covered under another health benefit plan, the Healthy Families Program, or no share-of-cost Medi-Cal coverage at the time the individual was eligible to enroll;

   b) He or she certified at the time of the initial enrollment that coverage under another health benefit plan, the Healthy Families Program, or no share-of-cost Medi-Cal coverage was the reason for declining enrollment, provided that if the individual was covered under another health benefit plan, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollment;

   c) He or she has lost or will lose coverage under another health benefit plan as a result of termination of employment of the individual or person through whom the individual was covered as a dependent; change in employment status of the individual or of a person through whom the individual was covered as a dependent; termination of the other plan's coverage; exhaustion of COBRA continuation benefits; cessation of an employer's contribution toward an employee or dependent's coverage; death of the person through whom the individual was covered as a dependent; or legal separation or divorce; loss of coverage under the Healthy Families Program, as a result of exceeding the program's income or age limits, or loss of no share-of-cost Medi-Cal coverage and;
d) He or she requests enrollment within 31 days after termination of coverage or cessation of employer contribution toward coverage provided under another health benefit plan;

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

3. A court has ordered that coverage be provided for a spouse or minor child under a covered employee’s health benefit plan. The health plan shall enroll a dependent child within 31 days of presentation of a court order by the district attorney, or upon presentation of a court order or requested by a custodial party, as described in subdivision (j) of Section 14124.93 of the California Welfare and Institutions Code or Medi-Cal program.

4. For individuals who failed to elect coverage during their initial enrollment period, and the plan cannot produce a written statement from the employer stating that prior to declining coverage, the employee or dependent, or the individual through whom he or she was eligible to be covered as a dependent was provided with a signed acknowledgement of a Refusal of Personal Coverage form specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of his or her late decision to elect coverage, an exclusion from coverage for a period of 12 months, as well as a six-month pre-existing condition exclusion, unless he or she meets the criteria specified in paragraphs (1.), (2.), or (3.) above; (pre-existing exclusion not applicable to HMO), or

5. For eligible employees or dependents who were eligible for coverage under the Healthy Families Program or Medi-Cal and whose coverage is terminated as a result of the loss of such eligibility, provided that enrollment is requested within 31 days after notification of this loss of coverage or;

6. For eligible employees or dependents who have lost their coverage under the Healthy Families Program as a result of exceeding the program’s income or age limits and who request enrollment within 31 days after notification of this loss of coverage.

7. For eligible employees who decline coverage during the initial enrollment period and subsequently acquire dependents through marriage, birth, or placement for adoption, and who enroll for coverage for themselves and their dependents within 31 days from the date of marriage, birth, or placement for adoption.

Additionally, late enrollees do not include the following employees:

- New hires - Employees in groups who are hired after the group’s effective date.
- Re-enrollees - Employees and eligible dependents of any employer group with 2 to 50 employees, who choose to discontinue health coverage and later wish to re-enroll.
- Replacement group/members - All eligible employees/dependents of an employer group who were covered as a group by a prior carrier.

Section VIII: Industry and COBRA Loads

Rating factors used for Employer Questionnaire RAF assignment

- SIC Codes* - depending on the amount of employer contribution, groups in certain industries may receive a decrease in the RAF.

*Standard Industry Code

- Calculation of COBRA loads - For every 10% of COBRA and/or Cal-COBRA enrollment, the RAF will be increased by .05.

<table>
<thead>
<tr>
<th># of Enrolling Employees</th>
<th># of COBRA</th>
<th>RAF Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>2</td>
<td>+.05</td>
</tr>
<tr>
<td>20</td>
<td>4</td>
<td>+1.0</td>
</tr>
<tr>
<td>20</td>
<td>1</td>
<td>No impact on RAF</td>
</tr>
</tbody>
</table>

- Responses to the medical questions

Non-guaranteed issue 51 to 299 carve-out groups only

Moratorium Codes - Groups with the following SIC codes will not be considered for coverage.

<table>
<thead>
<tr>
<th>Industry</th>
<th>SIC Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture/Forest/Fish</td>
<td>0101-0191, 0711-0724, 0761, 0912-0971</td>
</tr>
<tr>
<td>Business (Employment/Staffing Agencies)</td>
<td>7360, 7361, 7363</td>
</tr>
<tr>
<td>Health (Healthcare Providers/Facilities)</td>
<td>8051-8052, 8059, 8062-8063, 8069, 8092-8093</td>
</tr>
<tr>
<td>Legal Services</td>
<td>8111</td>
</tr>
<tr>
<td>Non-Classifiable</td>
<td>9999</td>
</tr>
</tbody>
</table>
Section IX: State and Federal Regulations

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

Cal-COBRA/COBRA continuation coverage
- Cal-COBRA (Cal Health & Safety Code & 1366.20 et seq.) became effective January 1, 1998. (Applies to groups of 2 through 19 eligible employees)
- Blue Shield administers Cal-COBRA for employers not subject to COBRA. Every California employer who provides group health coverage and who employed 2 to 19 employees on at least 50% of its working days during the preceding calendar year or, if the eligible employer was not in business during any part of the preceding calendar year or, if the eligible employer was not in business during any part of the preceding calendar year, employed 2 to 19 eligible employees on at least 50% of its working days during the preceding calendar quarter, is subject to Cal-COBRA.
- For these employer groups, Blue Shield of California will administer Cal-COBRA. Under Cal-COBRA, employers are required to notify Blue Shield within 31 days when an employee terminates employment or is no longer eligible due to a reduction of work hours. Employees that are terminated for “gross misconduct” are not eligible for Cal-COBRA. To notify Blue Shield, please fill out a Cal-COBRA Employer Notification form (C13140) and forward to the address on page 35. After receipt of the notification, Blue Shield will forward information regarding benefits, rates and a Cal-COBRA Election form (C13141) to the employee.

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

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

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

Dues for Cal-COBRA enrollees will remain at 110% of the group rates, even for enrollees who are disabled. Dues for COBRA enrollees who elect the Cal-COBRA extension are also 110%. Dues for disabled COBRA enrollees are 150% of applicable group dues. Please note that all COBRA coverage must be exhausted, including the disability extension, before the COBRA enrollee is eligible for the Cal-COBRA extension.
We have established a centralized, dedicated team to administer Cal-COBRA. The Cal-COBRA team is located at this address:

Blue Shield of California
Cal-COBRA
P. O. Box 629009
El Dorado Hills, CA 95762-9009
Phone: (800) 228-9476 Fax: (916) 350-7480

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

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

- Receive notices from the employer or enrollee regarding qualifying event.
- Process notices of qualifying events and apply eligibility determinations.
- Provide Cal-COBRA packets to eligible applicants (employees and/or dependents) within 14 days of receipt of the notice of a qualifying event.
- Collect monthly payments for the duration of the Cal-COBRA coverage.
- Provide customer service for billing and eligibility questions.
- Process cancellations.

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

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

Federal COBRA coverage
Generally, every employer who provides group health coverage and who employed 20 or more full- and/or part-time employees during 50% of the business days in the previous calendar year is subject to federal COBRA. For employers subject to COBRA, Blue Shield has contracted with CONEXIS COBRA Continuation Services to provide COBRA administration of our accounts. Employers that waive the services of CONEXIS will be responsible for administering their own COBRA.

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

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

This extension of coverage will end on the earliest of the following dates:

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

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

HIPAA requirements after COBRA and Cal-COBRA termination
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans, their producers and employer groups to proactively identify individuals who may qualify for guaranteed issue individual plan coverage, as required by HIPAA, and advise them of this coverage. A guaranteed issue individual plan under HIPAA is only available after exhaustion of COBRA and/or Cal-COBRA (includes the Cal-COBRA extension for COBRA enrollees) benefits and only if the most recent coverage was group coverage (COBRA and Cal-COBRA are considered group coverage). Therefore, individuals who have exhausted their COBRA benefits and/or Cal-COBRA benefits are potential HIPAA-eligible individuals, and should be advised of their HIPAA rights before being offered “individual” conversion or short-term coverage, which would cancel HIPAA guaranteed issue eligibility. These individuals must apply for a HIPAA guaranteed issue plan within 63 days after group coverage.
Employer option to include part-time employees

Under AB 1672, a small group employee is required to work a minimum of 30 hours per week to be eligible for coverage. However, state law also provides the employer an option to offer coverage to part-time employees, as long as the following criteria are met:

All other eligibility requirements as a small group are met (refer to Section I, pages 4 and 5 of this guide, “Definition of small employer group”).

- The employer offers coverage to all similarly situated employees. For example, if an employer chooses to offer coverage to employees working 23 hours per week, then all employees working a minimum of 23 hours or more per week are to be offered coverage. Enrollment Applications and Refusals must be submitted for all eligible employees.
- The employer must indicate the intent to offer coverage under this option on the Master Group Application, as well as state the minimum weekly hours chosen (no fewer than 20). No off-anniversary exceptions will be granted to add part-time employees.
- The part-time employees being offered healthcare coverage must have worked a minimum of 50% of the preceding calendar quarter. This is an individual eligibility requirement for each part-time employee being offered coverage under this option.
- If eligibility is not met by the individual employee at the time of group enrollment, the employee must wait until evidence of hours worked can be provided per the DE-6. Once eligibility is met, enrollment must take place within 30 days of meeting the eligibility requirement. If not, the employee will not be eligible to enroll until the next open enrollment period at renewal.
- This employer option may be added to the group plan at the yearly renewal period. Part-time employees may not be added to the group plan unless the employer has stated in writing that this feature is available, and the prior quarter’s DE-6 is submitted.
- Eligibility for small group enrollment must remain valid after the inclusion of part-time employees. If the inclusion of part-time employees raises the eligibility count to over 50, then the group no longer qualifies as a small group under AB 1672, and must be submitted as a large group.

If you need more information about eligibility under this option or AB 1672, please contact your Blue Shield of California representative.

Mental Health Parity and Addiction Equity Act of 2008

The Federal Mental Health Parity and Addiction Equity Act (HR 1424) requires that if a health plan provides mental health or substance abuse benefits, that coverage must be at parity with or at a level equal to the plan’s existing medical benefits coverage.

- Affected small groups with coverage issued or renewed on or after October 15, 2009 that offer mental health or substance abuse coverage will receive updated plan benefits at their qualifying renewal date once Blue Shield is notified that the group is subject to HR 1424 (“impacted group”).
- An impacted group meets the federal definition of “large group” if they have or have had more than 50 total employees, including seasonal and/or part-time employees, for at least six months during the prior calendar year. Eligibility for small group guaranteed issue coverage is based on the number of eligible employees rather than total employees. It is possible for a group to meet both the state definition of a small employer and the federal definition of large employer at the same time.
- Groups will only receive HR1424 compliant benefits if Blue Shield is notified of their requirement to comply with HR1424. Since group size is based on the total number of employees for the prior calendar year, the current number of enrolled employees does not determine whether the group is subject to HR 1424.
- Groups requesting to receive HR1424 compliant benefits will be required to submit a copy of two DE6’s from the prior calendar year to verify eligibility for the benefits.

Takeover provisions (California State Insurance Code)

Blue Shield small group takeover provisions comply with the following:

- Any carrier providing replacement coverage with respect to hospital, medical, or surgical expense or service benefits within a period of 60 days from the date of discontinuance of a prior contract or policy providing such hospital, medical, or surgical expense or service benefits shall immediately cover all employees and dependents who were validly covered under the previous contract or policy providing such hospital, medical, surgical expense, or service benefits at the date of discontinuance, and are within the definitions of eligibility under the succeeding carrier’s contract, regardless of any provisions of the contract relating to active full-time employment or hospital confinement or pregnancy.
Confidentiality of personal and health information

Blue Shield is committed to maintaining the confidentiality of our members’ personal and health information (PHI). This includes both medical and individually identifiable information, such as addresses, Social Security numbers, health plan identifiers, and telephone numbers, etc. Because we believe that the privacy of members’ personal and health information is critical to their receiving quality health care, we strive to ensure that this information remains confidential. We maintain our confidentiality policies throughout all divisions of our organization.

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

When a prospective member completes an application for Blue Shield healthcare coverage, his or her signature authorizes us to collect information about health care to evaluate that application. If that person becomes a Blue Shield member, this general authorization allows us to communicate with that member’s physicians and other providers regarding treatment, payment, and healthcare operation decisions.

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

We will not disclose, sell or otherwise use members’ personal and health information unless permitted by law, and to the extent necessary to administer the health plan. We will obtain a written authorization from a member to use his or her personal and health information for any other purpose other than treatment payment or healthcare operations. We will not release a member’s personal and health information without that member’s specific authorization, unless the law permits such a release.

For any of our prospective or current members, who are unable to give an authorization, we have a policy in place to protect their rights. This policy permits their legally authorized representatives to authorize the release of their personal and health information.

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

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

Meeting your obligations under AB 1672

1. Providing health coverage information

Any producer, solicitor, or solicitor firm providing general information on coverage to a small employer.

(2 to 50 eligible employees), but not specifically recommending particular health plan contracts, must:

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

b) Notify the employer that, upon request, you will provide the carrier’s Benefit Summary Guide and rate and benefit information on any small employer health plan contract offered by that carrier.

c) Any producer, solicitor, or solicitor firm that is recommending a particular health plan contract must advise the small employer that, upon request, he or she will provide that plan’s Benefit Summary Guide. To obtain Blue Shield’s Benefit Summary Guide (A16609), you may either download the document from the collateral section of our Producer Connection at blueshieldca.com or call Producer Services at (800) 559-5905 for a copy.
2. **Submitting an application**

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

a) Provide the employer with the Blue Shield's Benefit Summary Guide and the sum of the standard employee risk rates for every Blue Shield plan contract offered to small employers;

b) Notify the small employer that actual rates may be 10% higher or lower than standard employee risk rates, depending on how the small employer's risk is assessed; and

c) Notify the small employer that for any contract Blue Shield offers to small employers, upon their request you will submit information to Blue Shield to determine their group’s possible RAF.

3. **Certifying your compliance**

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

4. **Things you must avoid**

You cannot, either directly or indirectly:

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

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

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

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

If you willfully violate provisions of AB 1672, you are liable for a penalty of not less than $250 for the first violation, and a penalty of not less than $1,000, or more than $2,500, for each subsequent violation. In addition, you will be in breach of your Blue Shield Producer's Agreement and could be held liable for damages under such a breach or terminated because of such a breach.

**Section X: Appendix**

**Form names and form numbers**

- **Master Group Application** – groups 2 to 50 (C-15385)
- **Employee Application** – groups 2 to 50 or Non GI group (C-12914)
- **Verification and Statement of Understanding** (C-20283)
- **Employee Health Statement** 2 to 14 (C-15825)
- **Blue Shield Domestic Partnership Statement** (C-14938)*
- **Blue Shield Life Domestic Partnership Statement** (C-15388)*
- **Subscriber Change Request** (C-675-1)
- **Refusal of Personal Coverage** (C-13124)
- **Full-time Student Certification** (C-13125)
- **Cal-COBRA Takeover** (C-14755)
- **Cal-COBRA Employer Notification** (C-13140)
- **Cal-COBRA Election** (C-13141)
- **COBRA Election** (C-11825)
- **Subscriber Statement of Disability** (C-12198)
- **Employer Questionnaire** (C-15146)
- **Sole Proprietor, Partner, or Corporate Officer Statement** (C-15293)
- **Probable Action** (C-15408)
- **Exception to Standard Enrollment** (C-15411)

*Not required for Blue Shield enrollment. For employer’s use only if they want to require an affidavit.