Large Group Administrator's Guide

Managing your group coverage: Membership claims and administration for groups with 101+ eligible employees

Effective January 1, 2025

blueshieldca.com/employer

Welcome to Blue Shield

This guide provides you with all the information you need to quickly enroll your employees and manage your group benefits. Inside you'll find a list of contacts, easy instructions on how to enroll your employees, useful information on programs and services, and fast answers on payments and processes.

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

If you have any questions, Blue Shield's customer service representatives and your dedicated sales representative are standing by to help you get the job done. We look forward to serving you. Thank you for choosing Blue Shield of California.

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Getting started online

Blueshieldca.com

For your employees

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

Select 'Coverage & benefits' to:

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

Select 'Find a Doctor' to:

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

Select 'Be Well' to:

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

Select 'Prescriptions' (under Benefits) to:

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

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

Employer Connection

Finding information is simple. Just go to **blueshieldca.com/employer** and select 'Log in or register' to get started. Visit **blueshieldca.com/ecp-getting-started** to see the library of quick demos on the various features of Employer Connection.

Once registered, you'll be able to:

- Manage your group's medical, dental, vision, and life insurance plans.
- Make one-time payments or set up automatic payments.
- Download and review current and past Blue Shield invoices.
- Enter your employees' open enrollment selections upon renewal.
- Create/manage additional users for your Employer Connection account.
- Create and download census and billing reports.
- Electronic enrollment options are available. For more information, contact your Blue Shield representative.

Plans & services

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

Employer resources

Managing your healthcare coverage doesn't have to be a hassle. At Blue Shield we are continually working to bring you the information you need, quickly and efficiently. In this section of the website, you'll find employer admin resources, answers to our most frequently asked questions, and more.

Forms

In this section, you'll find enrollment forms, addition, changes and deletions forms, and claim forms. Complete fillable PDFs online and then print, sign and submit them to Blue Shield.

Why Blue Shield?

Discover our advantages, including large provider networks, plan flexibility and choice, wellness programs, and strong industry leadership.

Contact information

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

Contact	For help with	Contact information
Core Elite client	Questions about group health plan eligibility, escalated issues, dental, vision, and complex claims questions	Core Priority **(855) 747-5809** or email by regions: 8 a.m. to 5 p.m. Pacific time, Monday – Friday corepriority@blueshieldca.com Shield Elite **(844) 831-4134** or email by regions: 8 a.m. to 5 p.m. Pacific time, Monday – Friday shieldelite@blueshieldca.com
Group billing representative	Billing issues	Group billing **(916) 350-7595** group.billing@blueshieldca.com
Eligibility	Employee enrollments, changes, or cancellations	Processing requests: LargeGroupDP@blueshieldca.com
Cal-COBRA administration	Cal-COBRA eligibility, coverage, extensions, and cancellations	Blue Shield of California Cal-COBRA **(800) 228-9476** Fax: **(916) 350-7480** 8 a.m. to 5:30 p.m. Pacific time, Monday – Friday Blue Shield of California Cal-COBRA Administration P.O. Box 629009 El Dorado Hills, CA 95762-9009
Employer-administered flexible spending account (FSA)	Questions about FSA programs	HealthEquity **(866) 382-3510** employerservices@healthequity.com
Life/AD&D	Questions about claims, declined services, or minor beneficiaries	**(888) 800-2742** 9 a.m. to 5 p.m. Pacific time, Monday – Friday

Eligibility & enrollment

Eligibility requirements at a glance

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

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

* The Patient Protection and Affordable Care Act redefined dependent children as of September 23, 2010 (for employer-sponsored plans, the later of September 23, 2010, or the first plan-renewal date thereafter).

Employee eligibility

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

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

Full-time employees

Full-time employees are eligible for coverage if they:

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

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

Part-time and temporary employees

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

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

Rehired employees

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

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

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

> **Please note:** Reemployment notification must be indicated on the rehired individual's employee application.

Dependent eligibility

This section covers eligibility requirements for five categories of dependents.

Spouses

An employee's legally married spouse is eligible for dependent coverage if they are not legally separated from the employee.

Domestic partners

Blue Shield plans cover domestic partners under the same terms and conditions as spouses, and domestic partners follow the same enrollment procedures as spouses. A domestic partner is an individual who is personally related to the Subscriber by a domestic partnership that meets the following requirements:

1. Both partners are 18 years of age or older, except as provided in Section 297.1 of the California Family Code
2. The partners have chosen to share one another's lives in an intimate and committed relationship of mutual caring
3. The partners are:
    a. Not currently married to someone else or a member of another domestic partnership, and
    b. Not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited
4. Both partners are capable of consenting to the domestic partnership; and
5. The partners have filed a Declaration of Domestic Partnership with the Secretary of State. (Note, some Employers may permit partners who meet the above criteria but have not filed a Declaration of Domestic Partnership with the Secretary of State to be eligible for coverage as a Domestic Partner under the plan.

If permitted by your company, such individuals are included in the term "Domestic Partner" as used in the Evidence of Coverage; however, the partnership may not be recognized by the State for other purposes as the partners do not meet the definition of "Domestic Partner" established under Section 297 of the California Family Code).

Dependent children

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

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

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

Enrollment paperwork for court-ordered dependent children must be submitted as soon as possible. Include a copy of the employee's Subscriber Change Request form and a copy of the employee's court orders. If the employee is not currently enrolled, they need to complete an Employee Application.

Disabled over-age dependent children

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

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

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

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

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

Qualified Medical Child Support Order (QMCSO)

A dependent child who is ordered to have coverage by the court cannot be denied because they are:

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

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

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

Ineligible individuals

These individuals are not eligible for Blue Shield group coverage:

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

Ineligible individuals for HMO/POS plans only:

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

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

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

Enrollment procedures at a glance

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

Quick reference for enrollment procedures

Enrollee	Eligibility	Time to report	Documents required	Accessible online
New employees and their dependents	The first billing date after the new employee completes your group's waiting period	Within 31 days of the employee's eligibility date	Employee Application; Eligibility Change Transmittal; or Self-Reporting Group Subscriber Report	🖥
Current employees transferring from one health plan to another	Effective date of your group's open enrollment provision	Open enrollment	Subscriber Change Request, Eligibility Change Transmittal, or Self-Reporting Group Subscriber Report	🖥
Employees or dependents who lose other group, Medi-Cal, or Healthy Families coverage	The date the employee or dependent loses the other group coverage	Within 31 days after the employee or dependent loses the other group coverage	The individual's Refusal of Personal Coverage section of the Employee Application; written evidence of loss of coverage; Employee Application; Subscriber Change Request (for dependents only); Eligibility Change Transmittal; or Self-Reporting Group Subscriber Report	
Rehired employees	If rehired within six months, effective date of rehire; If rehired after six months have elapsed, effective the first billing date after the employee completes your group's waiting period	Within 31 days of the employee's eligibility date	Employee Application; Eligibility Change Transmittal; or Self-Reporting Group Subscriber Report	🖥

Enrollee	Eligibility	Time to report	Documents required	Accessible online
Spouses	The date of marriage; or the date they lost their other group coverage	Within 31 days after the marriage; or within 31 days after the loss of their other group coverage	Employee Application; Eligibility Change Transmittal; or Self-Reporting Group Subscriber Report	
Domestic partners	The date of partnership; or the date they lost their other group coverage	Within 31 days after partnership is declared or established; or within 31 days after the loss of their other group coverage	Employee Application; Eligibility Change Transmittal; or Self-Reporting Group Subscriber Report	
Newborns	The date of birth	Within 31 days of birth	Employee Application; Eligibility Change Transmittal; or Self-Reporting Group Subscriber Report	
Adopted dependents	The date the employee, spouse, or domestic partner has the right to control the child's health care	Within 31 days of the date the employee, spouse, or domestic partner has the right to control the child's health care	Written proof of the right to control the health care of the child, such as a medical authorization form; a health facility minor release form, or a relinquishment form; Employee Application; Eligibility Change Transmittal; or Self-Reporting Group Subscriber Report	
Dependents subject to a court order for medical support	The date the court order is issued (or the date specified in the court order)	Earliest possible date	A copy of the court order; Employee Application; Eligibility Change Transmittal; or Self-Reporting Group Subscriber Report	

Annual open enrollment

Here's a guide to help you easily understand the enrollment process, so it goes smoothly for you and your employees.

What is open enrollment?

Open enrollment is a window of at least 30 days for the employee to select their medical, dental, and vision benefits. You can arrange a benefit meeting to review the plan benefit offerings and value-added programs, and to help answer employee questions. Open enrollment should be at least 30 days in duration and conclude no later than 10 working days prior to the group's effective renewal date of coverage. You may contact your Blue Shield sales representative to help you coordinate the meeting. However, open enrollment benefit meetings are not mandatory.

During this time:

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

What do employees need to complete during open enrollment?

Open enrollment changes can be completed through an established electronic enrollment connection or online using Employer Connection.

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

If the employee decides to make a plan change, or add or delete dependents, log in to **blueshieldca.com/employer**. Find the employee in the member roster, select the employee, and select Update Subscriber Group to begin making changes.

An alternative way to make enrollment changes is to complete paper forms. The employee will have to complete a Subscriber Change Request form. Additional forms may be required depending on the circumstance. For example, if the employee has disabled children, they will need to submit a Declaration of Disability for Over-Age Dependent Children form (C3674) or Refusal or Cancellation of Personal Coverage form (C13124) if the dependent is over-age or on a medical leave from a college or trade school.

For open enrollment information on:

- Dental coverage, see page 38
- Vision coverage, see page 42

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

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

Employees who are absent during open enrollment

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

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

Please note: If an employee who enrolls in Blue Shield's Access+ HMO or Trio HMO doesn't choose a primary care physician during the open enrollment period, Blue Shield will indicate the assigned provider on the ID card, which will remain in effect until the employee chooses a different primary care physician.

Adding dependents

To add a dependent (e.g., newborn child, a spouse, or an adopted child), you can easily add the dependent through your electronic enrollment tool or on Employer Connection. Simply log in at **blueshieldca.com/employer**. Select the member from the member roster and select Update Dependent Status. Then follow the steps online to add a new dependent. Another way to add a dependent is to have the employee complete and submit the paper version of the Subscriber Change Request form. **Please make sure that HMO and POS members select a primary care physician for each dependent.**

To add a newborn child, employees must complete and submit the Subscriber Change Request form within 31 days from the child's date of birth. For the first 31 days, HMO members must select a primary care physician for the child who is with the same IPA or medical group as the mother's PCP. After 31 days, the newborn child will be considered a late enrollee. (See page 20 for more information on late enrollment.)

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

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

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

Selecting a primary care physician (HMO, Trio HMO and POS plans only)

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

Your employee must select a PCP who is located near their home or work address for reasonable access to care. However, each of the employee's dependents may choose their own PCP.

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

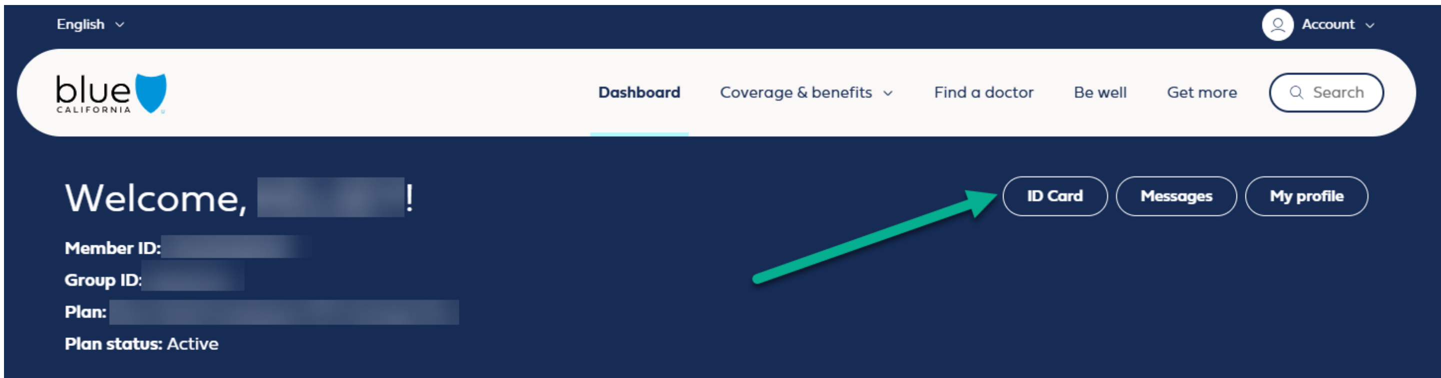
- Do not select a PCP when they enroll in a Blue Shield Access+ HMO or POS plan
- Select a doctor who is not a participating physician in the Access+ HMO provider network
- Choose a specialist who is not also a PCP
- Select a doctor who is not accepting new patients, unless the employee is a current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

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

Member ID cards

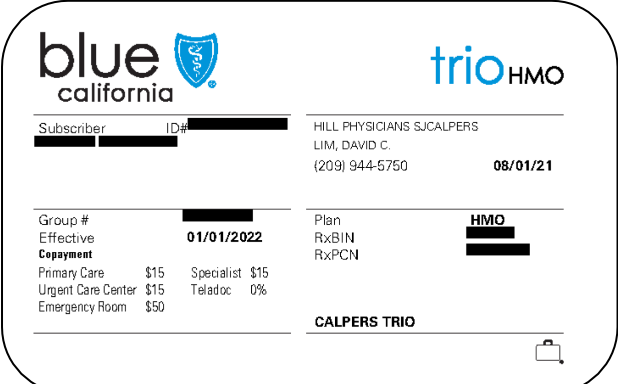
The member ID card identifies your employee as a Blue Shield member. If you offer dental HMO or dental PPO coverage, a separate ID card will be issued. Your employees should carry their Blue Shield ID cards with them at all times.

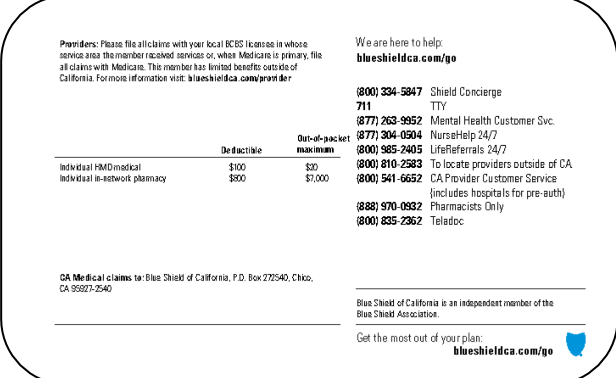
Members can order or access their digital ID cards by registering their account on **blueshieldca.com**. Once registered, their ID cards will be on their dashboard page and can click on their initials in the upper right corner. They can select ID card from the menu. Members can view or order ID cards directly from this page, or call the number on their Blue Shield ID card.



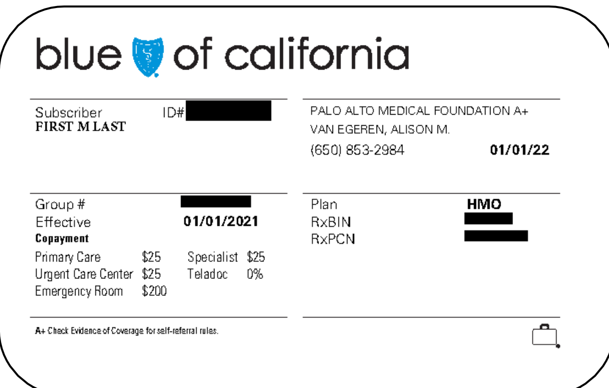
If they lose their card, they can call Member Services. Members can also view their member ID card on the Blue Shield mobile app. Our mobile app provides enhanced 24/7 service and ease-of-access to health plan information. If members are enrolled with digital preference for plan and benefit they will receive a digital ID card.

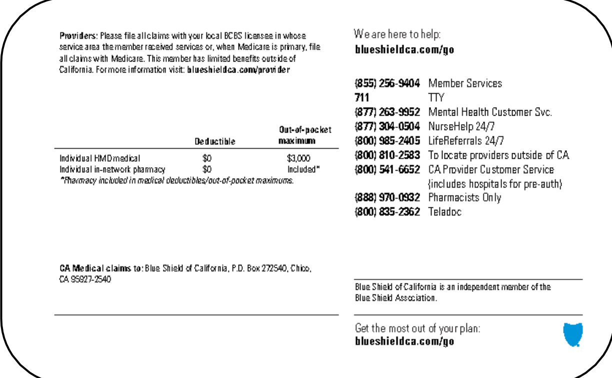
Trio HMO ID card sample



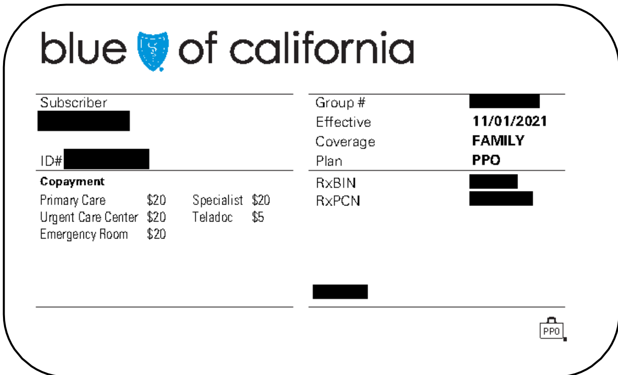


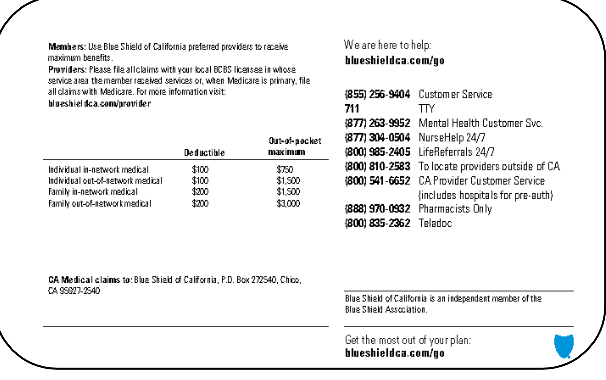
HMO ID card sample





PPO ID card sample





Dental HMO ID card sample

blue of california

Subscriber
SUBSCRIBER BSD_LAST
ID#
100000027

Effective date **10/01/18**
Card issue date **06/22/20**

Dentist **DENTIST, DR.**
Dentist ID **000000000000**
Dental Center
FAMILY DENTAL GROUP

Dental Identification Card

Plan - **Dental HMO**

blue of california

Carry this identification card with you at all times and present it whenever you or one of your enrolled dependents receives dental services. Read your *Evidence of Coverage* booklet, which sets forth the benefits, limitations, and exclusions of your dental plan contract.

Blue Shield of California is an independent member of the Blue Shield Association.

There are no plan benefits outside of California.

(800) 585-8111 Dental Customer Services

Benefits of the Dental Plan, other than emergency care, are available only when you receive covered services from the dentist selected by the member. Benefits for specialty covered services are provided only on referral from your dentist.

Submit claims to:
Blue Shield of California
P.O. Box 30567, Salt Lake City, UT 84130-0567

Dental PPO ID card sample

Subscriber
SUBSCRIBER BSA_LAST
ID#
100000021

Effective date **10/01/18**
Card issue date **06/22/20**

Dental Identification Card

Plan - **Dental PPO**

blue of california

Carry this identification card with you at all times and present it whenever you or one of your enrolled dependents receives dental services. Read your *Evidence of Coverage* booklet, which sets forth the benefits, limitations, and exclusions of your group's dental plan contract.

Blue Shield of California is an independent member of the Blue Shield Association.

Network access in your market may also be provided by: CONNECTION Dental, MaximumCare. Additional discounts may also be available through Zelis, an out-of-network network partner.

(888) 702-4171 Dental Customer Services

Network benefits apply when you receive covered services from a network dentist. In-network benefits are paid based on applicable percentages of Maximum Allowable Charge (MAC) Schedules. Benefit percentages and amounts may vary between network and non-network dentists. There may be waiting periods for some procedures.

Submit claims to:
Blue Shield of California
P.O. Box 30567, Salt Lake City, UT 84130-0567

Vision ID card sample

blueshieldca.com/go
Member/Patient Services: (877) 601-9083
Blue Shield CA Insight Network
Blue Shield of California
SUSAN SAMPLE
Member ID: 123456
Group #: 1050669
Effective: 02/01/2024

Blue Shield of California is an independent member of the Blue Shield Association

> Blue Shield will issue ID cards to members within two weeks after they enroll in your Blue Shield group plan.

Evidence of Coverage or Certificate of Insurance (COI)

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

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

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

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

Late enrollment

Managing late enrollment

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

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

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

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

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

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

Exceptions to late enrollment

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

- Was covered under another group-sponsored health plan at the time they were eligible to enroll;
- Lost Medi-Cal or Healthy Families Program coverage as an exception to late enrollment;
- Certified on the "Refusal of Personal Coverage" section of the Employee Application during initial enrollment that coverage under another group-sponsored health plan was the reason for declining enrollment (Individual and Family Plans do not qualify as another group-sponsored health plan);
- Lost or will lose coverage under their other group-sponsored health plan if any of the following six situations occur:
    1. Employment of the original plan subscriber (such as the employee's spouse or domestic partner) is terminated.
    2. Employment status of the original plan subscriber (such as the employee's spouse or domestic partner) changes. For example, the employee's spouse begins working as a part-time employee rather than a full- time employee.
    3. The other group-sponsored coverage is terminated.
    4. The company sponsoring the other group-sponsored health plan is no longer contributing to coverage. For example, if your employee's spouse's company stops contributing to coverage under its health plan, your employee could apply for Blue Shield coverage and would not be considered a late enrollee.
    5. The original subscriber of the employee's health coverage dies.
    6. Your employee gets a divorce from the original subscriber of the other group coverage.

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

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

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

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

Initial enrollment for new employees

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

- New employees are eligible for coverage after completing your group's waiting period (if any). The same applies to new employees' dependents.
- Blue Shield does not waive the waiting period for new employees unless your group's contract specifies that the waiting period will be waived for certain employee positions. You can make changes to these position specifications during renewal.

- Blue Shield must receive a completed Employee Application no later than 31 days after a new employee completes your group's waiting period.
- Employees and dependents who decline coverage during their initial 31-day enrollment period must complete the "Refusal of Personal Coverage" section of the Employee Application. Please retain a copy of the completed "Refusal of Personal Coverage" section. Blue Shield does not require submission of Refusal of Coverage forms.

Renewal

This is a period when the employer can:

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

Credit for prior coverage

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

Access to Language Assistance Services

Blue Shield provides:

- No-cost language services for members to reach an interpreter or have documents read aloud or sent in the mail. Language-assistance services to people whose primary language is not English such as qualified interpreters and information written in other languages. Call the phone number on the Blue Shield member ID card or **(866) 346-7198**.
- Aids and services at no cost to people with disabilities to communicate effectively with us. Aids and services include:
  - Qualified sign language interpreters and written information in other formats (including large print, audio, accessible electronic formats, and other formats).

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

Employee status changes

Name and address changes

Name and address changes can be made through your electronic enrollment tool or on Employer Connection. Simply log in at blueshieldca.com/employer to get to the Benefits Management tool and select the member name from your member roster. Then select Update Personal Information or Update Address once you reach the member information screen.

You can also make member address changes by submitting a request to largegroup.membereligibility@blueshieldca.com or by calling your Core Priority representative at **(855) 747-5809**.

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

Leave of absence

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

If your company requires employees to pay for their group health plan coverage during the leave period, payment must be made payable to your company and not to Blue Shield. Blue Shield will continue to include the name of the employee on leave on your monthly billing statement. If an employee is on an approved family leave and your company is subject to the federal Family and Medical Leave Act of 1993, payment of the employee's dues will keep coverage in force for the periods allowed by the Act.

The length of a leave of absence is determined by your company's personnel policy. Therefore, your company's policy determines if or when the employee on leave is terminated. You must notify Blue Shield when you terminate the employee by submitting the information by email to largegroup.membereligibility@blueshieldca.com. If an employee on leave is terminated, the individual may qualify for continuation coverage in the same manner as a terminated employee who was actively working on their last day of coverage.

Divorce or legal separation

When a member divorces, their dependent children do not lose eligibility, and may continue to be covered as the employee's dependents. If the employee decides to cancel the children's group coverage, they may elect COBRA on their own within the 60-day election period. The former spouse does lose eligibility under the group plan, but may be eligible for COBRA continuation coverage.

For more information, see the "Coverage cancellation and options for employees" section on page 24.

Termination of domestic partnership or divorce

When a domestic partnership terminates, group coverage of the employee's domestic partner and their children will terminate at the end of the month in which the domestic partnership termination or divorce occurs. The employee's domestic partner and children are not eligible for federal COBRA. However, eligibility requirements for continued coverage under Cal-COBRA are different from federal COBRA, so they might be eligible for Cal-COBRA continuation coverage. The employee must provide Blue Shield with the domestic partner's forwarding address so that the individual can receive the appropriate Cal-COBRA notification by mail.

Claims process

Preferred providers (for PPO medical plans only)

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

Non-preferred providers (for PPO medical plans only)

If a non-preferred provider asks the member for payment immediately after the visit, the member should:

- Pay the bill; then
- Mail the itemized bill and a Subscriber's Statement of Claim form to Blue Shield.

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

Explanation of Benefits (EOB)

An EOB explains the actions taken on each claim a member or provider submits. The EOB tells a member how a submitted claim was processed and informs the member of their financial responsibility. The EOB is not a bill. However, it will reference any copayments the member owes for services (see page 57 for a sample EOB).

Grievance process

Blue Shield of California and Blue Shield of California Life & Health Insurance Company (Blue Shield Life) have established a grievance procedure for receiving, resolving, and tracking members' grievances with Blue Shield. Members, members' providers, or representatives on behalf of members can contact Member Services by telephone, online at **blueshieldca.com**, or by mail to request a review of an initial determination concerning a claim or service. Employees can reference their Evidence of Coverage or Certificate of Insurance for a detailed process overview about how to file a grievance, or log in to **blueshieldca.com** and click on Grievance Form toward the bottom of the page.

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

Coverage cancellation and options for employees

Employees or dependents who no longer qualify for your group's Blue Shield coverage may be eligible for extended coverage under COBRA or Cal-COBRA. Please advise your employees who are thinking of continuing group coverage under COBRA or Cal-COBRA to consider these options carefully before investigating individual health insurance. Companies that sell individual coverage require a review of an applicant's medical history that could result in a higher premium or a complete rejection.*

And, an individual is not eligible for an individual conversion plan (ICP) or a guaranteed-issue individual plan as required by federal law (HIPAA) unless all group coverage options are exhausted including COBRA and Cal-COBRA.

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

- Report coverage cancellations to members who are no longer eligible
- Notify us prior to each individual's last day of eligibility, whenever possible, by submitting the request to **LargeGroupDP@blueshieldca.com**

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

Cancelling employee and dependent coverage

Employee coverage cancellation

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

You can cancel an employee's coverage electronically through your electronic enrollment tool or on Employer Connection. Simply log in to blueshieldca.com/employer to link to the Benefit Management tool. Select the name of the individual to terminate from the member roster. On the member information page, select Terminate Subscriber on the right-hand side and follow the instructions on the screen.

Or, you may cancel an employee's coverage by submitting a request to **LargeGroupDP@blueshieldca.com**. Please include the employee's name, Blue Shield member ID number or Social Security number, and employment termination date.

Cancellation requests must be submitted within 30 days of the termination date. Blue Shield will provide credit based on the group's retroactive eligibility adjustment guidelines (i.e., current month plus 30, 60, or 90 days).

Helpful hints

- If you are cancelling an employee's coverage, do not list any dependent cancellations on the Self-Reporting
- Group Subscriber Report. When an employee's coverage is cancelled, all covered dependents lose eligibility and their group coverage is cancelled automatically. (You are a self-reporting group if you do not receive a billing statement.)
- If an employee voluntarily cancels their group coverage (when not terminating employment with your company), but later wishes to re-enroll, the employee must comply with the late-enrollee guidelines, which are outlined on page 20.
- Out-of-state employees covered under COBRA are not eligible for HMO or POS COBRA coverage if they are in an HMO or POS plan. However, they are eligible to transfer to a PPO plan if you offer one. Please contact your Blue Shield sales representative about continuation coverage for your out-of-state employees.

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

Dependent coverage cancellation

Dependents are no longer eligible for Blue Shield group coverage when the employee dies, terminates employment, or no longer works the minimum hours required for eligibility. Dependent children's coverage must also be cancelled (even when the employee's coverage is not cancelled) when they:

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

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

- A spouse who divorces or legally separates from a covered employee, and becomes ineligible for group coverage.
- The subscriber's dependent children, if the subscriber decides to cancel the dependent children from their coverage.
- A domestic partner and their children. When a domestic partnership terminates, group coverage of the employee's domestic partner and their children will terminate at the end of the month in which the domestic partnership termination occurs. The employee's domestic partner and children may be eligible for continued coverage under Cal-COBRA. For details, see the " Termination of domestic partnership or divorce" section on page 23.

> **Please note:** Federal COBRA does not require continued coverage for the domestic partner or children when the partnership is terminated.

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

1. Have the employee complete a Subscriber Change Request form and list the name(s) of the dependent(s) to be disenrolled and the date(s) of cancellation. The employee should complete this form during the month the dependent becomes ineligible for coverage.
2. Verify that the form is properly completed, signed, and dated, and give the employee a copy of the form.
3. If your group is self-reporting and doesn't receive a billing statement, enter the employee name on the Self- Reporting Group Subscriber Report and the dependent dues/premiums in the "Current Dues Deletions" column. Under "Remarks" note that a dependent is being disenrolled and indicate the effective date.
4. Mail, fax, or email the Subscriber Change Request to Blue Shield.

> **Please note:** Cancellation requests must be submitted within 30 days of the termination date.

Federal COBRA and state Cal-COBRA continuation coverage

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

General guidelines	
COBRA	• Applies to employers that employed 20 or more employees during at least 50% of the working days in the previous calendar year. • When the number of employees either increases to more than 19 or decreases to less than 20, you must wait until the first of the next calendar year and use the above guidelines before changing your administration of continuation of group coverage from Cal-COBRA to COBRA or from COBRA to Cal-COBRA.
Cal-COBRA	• Applies to employers that employed two to 19 employees for at least 50% of the working days in the previous calendar year. • Cal-COBRA is also available to the employees of employers subject to COBRA after the employees exhaust all available COBRA coverage, without reaching the COBRA coverage maximum of 36 months. • The Cal-COBRA continuation of coverage after COBRA is only available to employees in heath plans underwritten by Blue Shield.

COBRA coverage

Blue Shield does not provide federal COBRA administrator services. All employers are responsible for administering their own federal COBRA program. Groups have the option to self-administer their federal COBRA benefits or choose a third-party COBRA Administrator.

COBRA disability extension

A member may extend their 18-month COBRA coverage period to 29 months if, under the Social Security Act:

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

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

Cal-COBRA coverage for COBRA enrollees

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

These conditions apply:

- If elected, the Cal-COBRA coverage will begin after the COBRA coverage ends and will be administered by Blue Shield's Cal-COBRA Administration.
- COBRA enrollees must exhaust all the COBRA coverage that they are entitled to before they can become eligible to continue coverage under Cal-COBRA, with the exception of domestic partners when the partnership terminates.
- When the domestic partnership terminates, or the employee dies, the domestic partner may apply for continuation of group coverage under Cal-COBRA.
- Cal-COBRA coverage is immediately available because a domestic partner does not have COBRA eligibility unless the employee elects and remains enrolled in COBRA and includes the domestic partner as a dependent.

How to enroll in Cal-COBRA

The employer, the former employee, or eligible dependent should notify Blue Shield's Cal-COBRA Administration team at least 30 days prior to COBRA termination:

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

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

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

The dedicated Cal-COBRA team will perform these administrative and membership duties:

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

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

Individual conversion plan (ICP)

Former employees and their dependents may also qualify for an individual conversion plan. The ICP is only available if the employee has had group coverage for three or more consecutive months. Employers are responsible for notifying their employees of the availability, terms, and conditions of the ICP within 15 days of termination.

Notification requirements for COBRA plan administrators

- The COBRA enrollee should contact Blue Shield for more information about continuing coverage. If the enrollee elects to apply for continuation of coverage under Cal-COBRA, the enrollee must notify Blue Shield at least 30 days before COBRA termination.
- You or your COBRA administrator are responsible for notifying COBRA enrollees of their right to possibly continue coverage under Cal-COBRA at least 90 calendar days before their COBRA coverage will end.

Extension of benefits for disabled members

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

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

- Midnight on the day following a 12-month period from the date the group contract terminated
- The date when the covered person is no longer totally disabled
- The date on which a replacement carrier provides coverage to the member

Members may contact Direct Sales at **(800) 600-3007** with questions.

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

Filing for an extension of benefits for disabled members

To file for an extension of benefits, the parent/primary care physician must submit a Declaration of Disability for Over-Age Dependent Child form to Blue Shield.

Coverage options for employees & retirees who have Medicare coverage

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

Active employees

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

For active employees:

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

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

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

Employer groups that provide prescription drug benefits to Medicare Part D eligible individuals must submit the online disclosure form directly to CMS. The disclosure form that must be completed and submitted to CMS can be found at the CMS website at: cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm. Instructions are available at: cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage.

If the employer group does not provide prescription drug benefits to any Medicare Part D eligible individual, no disclosure form needs to be completed for the plan year.

* Creditability is indicated on the Pharmacy Benefit Summaries. Blue Shield 65 Plus is a service mark of Blue Shield of California.

Medicare claims appeal process

Members enrolled in Blue Shield 65 Plus Choice Plan (HMO) may contact the Member Services department at **(800) 776-4466** (TTY: 711) to appeal already adjudicated claims.

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

Blue Shield 65 Plus HMO
Medicare Grievances and Appeals - Resolution Department
P.O. Box 927
Woodland Hills, CA 91365-9856
Fax: **(916) 350-6510**

Member Services:

- Interactive Voice Response is available 24/7.
- Member Services is open seven days a week, 8 a.m. to 8 p.m. from October 1 through March 31, and Monday through Friday, 8 a.m. to 8 p.m. (Saturday and Sunday, 8 a.m. to 5 p.m.) from April 1 through September 30.

For additional coverage options for employees and dependents, please go to **blueshieldca.com**, select Employers, then click on Blue Shield Plans. You can also contact your Blue Shield sales representative to learn more about:

- Blue Shield Individual and Family Plans (IFP)
- Blue Shield Individual Conversion Plans
- Medicare Supplement Plan or Blue Shield 65 Plus℠ (HMO) for retirees with Medicare coverage

Billing

Group billing procedures

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

Billing statement quick checklist

Enclosed	Items*
✓	A check for your group's monthly dues payment
✓	The remit slip from the bottom of the billing statement's first page

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

Standard positive billed groups

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

- Submit cancellation requests within 30 days of the termination date. Retroactive cancellations are based on the group's retroactive eligibility adjustment guidelines (i.e., current month plus 30, 60, or 90 days) and must be submitted with your eligibility grace period. Retroactive cancellations that exceed 30 days will not be approved.
- Verify monthly that your changes are accurately reflected on the Group Payment Request.
- Send the billing statement remit slip with your monthly premium, along with a list of any terminations for the month.

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

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

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

If you have any questions about changes to your group's coverage, please contact Core Priority at **(855) 747-5809** or Shield Elite Team at **(844) 831-4134**.

> Coverage from Blue Shield is offered on a prepaid basis. Blue Shield must receive your group's dues on or before the due date to keep your coverage current. An "unpaid" status could cause your group's coverage to be suspended or cancelled in addition to the denial of unpaid claims.

Paying dues for new additions

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

If your eligibility changes are submitted via an ANSI 834 file, the Summary Report provided after each file needs to be reviewed and the appropriate actions taken to ensure accurate eligibility is reflected. This will allow Blue Shield to issue a correct monthly invoice that indicates the appropriate employees.

Terminations must be sent to the eligibility processing team. If your group utilizes a file feed, termination dates must be added to the group's file. Files received without termination dates will not terminate the member's coverage.

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

Stopping payment for deletions

If an employee is terminated during the month:

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

Identifying class and plan transfers

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

Group summary bill

Group and subgroup numbers

You will find group and subgroup numbers embedded within the account number located under the mailing address on your first month's bill. Your account number is "1" followed by your group number beginning with the letter "W" and followed by seven numbers, then followed by your subgroup number, which is four numbers.

Example:

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

Integrated bill format

A. Bill date
B. Billing period and due date
C. **Previous amount due:** The total amount due from the prior month's billing statement
D. **Payment**: Payment received since last billing statement

Excerpt from the group summary bill

Blue Shield of California
Installation & Billing
PO BOX 629032
EL DORADO HILLS CA 95762-9032

------ manifest line ---------

blue of california
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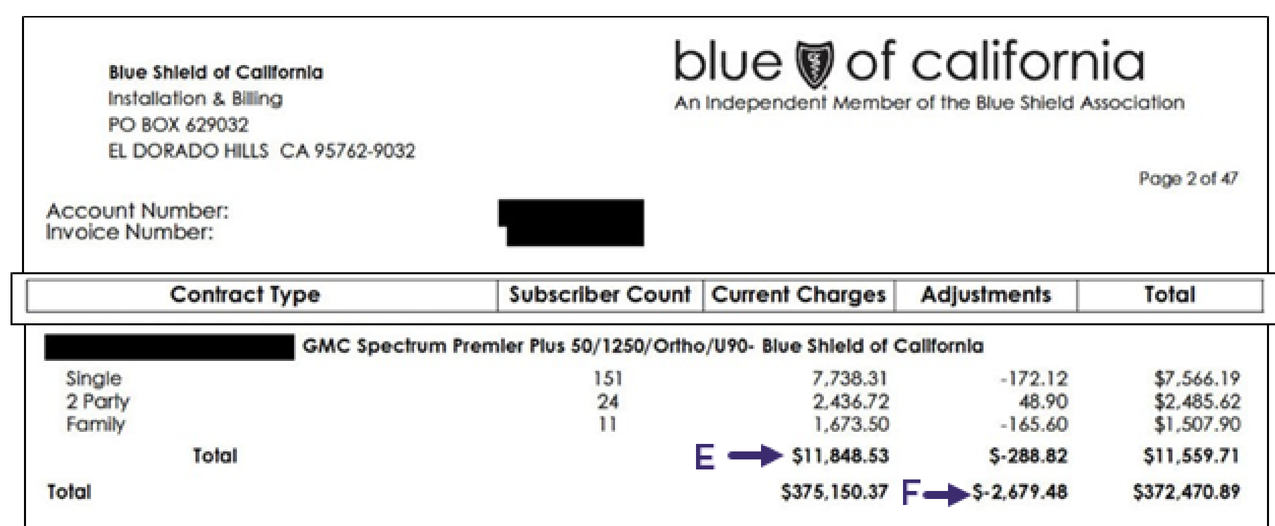
Summary

Bill Date:		09/21/22
Billing Period:		10/01/22-10/31/22
Due Date-Please pay within 15 days.:		10/01/22
Previous Amount Due:	$	396,655.63
Payments - thank you:		-396,655.63
Balance:		0.00
Current Charges:		375,150.37
Retroactive Adjustments:		-2,679.48
Net Credits/Debits		0.00
Total Amount Due:	$	372,470.89

Account Number:
Invoice Number:

Integrated bill format (continued)

E. **Billing detail:** Current charges
F. **Total current adjustment:** Identifies the net change of subscriber and member since last billing statement
G. **Membership summary:** Provides a summary of the number of subscribers and dues by products
H. **Contract counts:** Identifies a summary of contract counts
I. Total subscriber and total members: Identifies the number of subscribers and dependents with current charges
J. **Billing detail:** Employees can be listed with up to two identifiers: the identifiers are the Blue Shield subscriber ID, Social Security number, or employee number
K. **Billing detail:** Retroactive adjustments; this lists each subscriber with retroactive changes



Blue Shield of California
Installation & Billing
PO BOX 629032
EL DORADO HILLS CA 95762-9032

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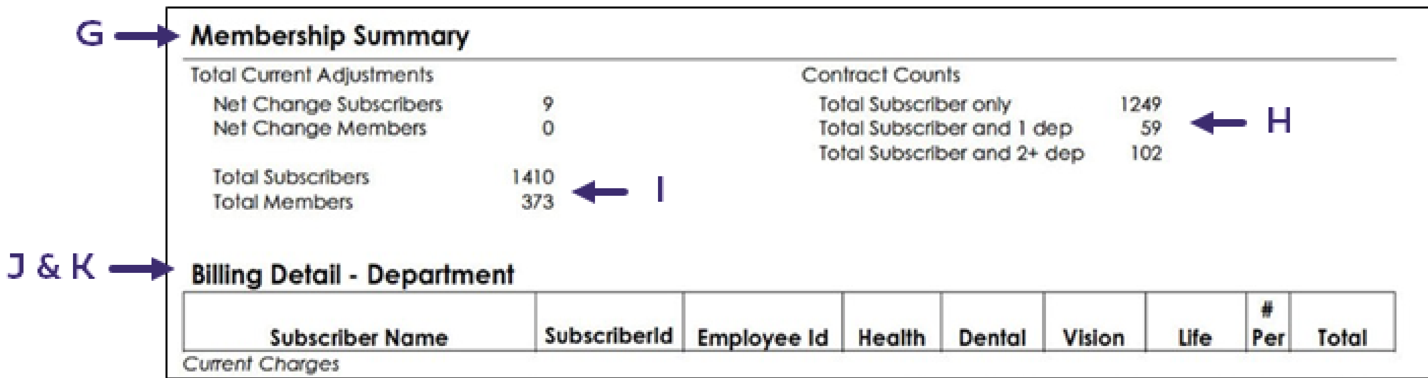
Account Number:
Invoice Number:

Contract Type	Subscriber Count	Current Charges	Adjustments	Total
GMC Spectrum Premier Plus 50/1250/Ortho/U90- Blue Shield of California				
Single	151	7,738.31	-172.12	$7,566.19
2 Party	24	2,436.72	48.90	$2,485.62
Family	11	1,673.50	-165.60	$1,507.90
Total		E → **$11,848.53**	**$-288.82**	**$11,559.71**
Total		**$375,150.37**	F → **$-2,679.48**	**$372,470.89**



G → **Membership Summary**

Total Current Adjustments
Net Change Subscribers 9
Net Change Members 0

Total Subscribers 1410
Total Members 373 ← I

Contract Counts
Total Subscriber only 1249
Total Subscriber and 1 dep 59 ← H
Total Subscriber and 2+ dep 102

J & K → **Billing Detail - Department**

Subscriber Name	SubscriberId	Employee Id	Health	Dental	Vision	Life	# Per	Total

Current Charges

Self-reporting billing procedures

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

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

Self-reporting billing quick checklist

Enclosed	Items*
✓	• A check for your group's monthly dues payment. • Always put your group ID, starting with a "W," on your payment. • If paying by wire, your group ID must be present on the wire payment.
✓	A Self-Reporting Group Subscriber Report

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

Important points about the Self- Reporting Group Subscriber Report

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

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

Payment backup procedures

Payment files must be submitted electronically in an Excel/ CSV format. The file can be submitted on a bimonthly or monthly basis. The frequency of submission will be determined during the initial group setup. Manual updates will not be accepted.

Because you do not receive a billing statement, Blue Shield will reconcile your payment file against our internal billing to ensure the accuracy of your group's eligibility. This procedure includes these steps:

- You or your third-party administrator (TPA) must submit the monthly payment report to the Billing Team.
- The required method of submitting monthly dues remittance information is an electronic Excel/CSV file format listing each individual and the billing period being paid.
- Do not send printed reports—they cannot be processed.
- The Excel/CSV file must be received no later than the first of the month that coverage is provided.
- Blue Shield will complete the reconciliation within 30 days of the payment and backup being received.
- Following the completion of the reconciliation, Blue Shield will return the payment discrepancies to the group or TPA within two business days. Note: The reconciliation will not start until accurate payment backup is received for each payment.
- The group or TPA has 10 business days to respond to Blue Shield. If no response is received, Blue Shield will assume the eligibility is correct. Any adjustments and/or corrections requested outside of the approved retroactive eligibility guidelines per the contract, will be declined.

It is the responsibility of the employer group to ensure their Trading Partner/TPA maintains accurate and timely eligibility updates to ensure accurate billing.

Cancellations and/or deletions must be reported on a timely basis so that retroactive dues adjustments do not exceed the approved retroactive eligibility guidelines outlined in the employer group contract.

Any cancellations and/or deletions requested beyond the retroactive eligibility guidelines will not be honored.

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

Grace Period Notice

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

- The start and end date of the 30-day grace period
- The date of cancellation if payment remains outstanding by the time the grace period ends
- A pre-addressed envelope for submitting the premium If you submit the outstanding premium payment on time and receive the 30-day Grace Period Notice in error, please contact your group billing representative by emailing **LargeGroupDP@blueshieldca.com**.

Delinquency

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

- Blue Shield is a prepaid health plan. You will be billed prior to the payment due date.
- Group premiums are due on the due date printed on the Group Bill.

If the group fails to make a premium payment by the due date, Blue Shield will send a Notice of Start of Grace Period to the group notifying them that past due payment has triggered a grace period starting from the day the notice is dated.

Group cancellation procedures

Requesting cancellation of your group account

Blue Shield requires 30 days' advance notice of cancellation in writing. Notification can be submitted by sending a letter on business letterhead.

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

Non-payment of premiums

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

Here is the procedure for late accounts:

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

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

How to manage your group dental benefits

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

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

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

Enrolling employees and dependents

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

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

If your eligibility changes are submitted via an ASNI 834 file, please submit all eligibility updates via that process.

Employee status change

You are responsible for maintaining accurate eligible employee information.

- A Subscriber Change Request form (C675-1) must be completed when there is a change in status to an employee, or their dependents, spouse, or domestic partner.
- In cases of births, adoptions, marriages, and divorces, the employee must submit the Subscriber Change Request form no later than 31 days after the change.
- If the employee does not submit the form within 31 days after the change, they will need to wait until your group's next open enrollment period.
- If the employee decides to add coverage for an existing dependent or spouse, the employee must wait until your group's next open enrollment period.
- Employees with family coverage should notify Blue Shield when a dependent child reaches age 26.

Invoice procedures

Membership changes should be faxed or mailed to Blue Shield prior to the 15th of each month to be reflected on the following month's invoice and Add/Change/Terminate Report. It is important to pay the amount shown on the invoice. Please do not subtract terminating employees' dues from the amount due as it will result in a negative balance on the next month's bill. For terminations:

- If using a file feed, please terminate members on the file. Note: Omissions do not generate a termination.
- If not using an electronic file feed, note terminations on Employer Connection and contact Large Group eligibility at LargeGroupDP@blueshieldca.com or contact Core Priority/ShieldElite.
- The amount will then be credited on the next billing and the account will remain current.

Open enrollment

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

Dental HMO plan provider change

Dental HMO members may change their current dental provider at any time by calling Dental Member Services at **(888) 702-4171.** Changes are effective the first day of the following month a request is received.

Submitting a claim

Dental HMO claims handling

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

Dental PPO claims handling

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

Nationwide dental provider network

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

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

- Going to **blueshieldca.com** to find a provider
- Calling Dental Member Services at **(888) 702-4171** to request a list of PPO or HMO dental providers

Forms

Forms for administering group dental benefits are listed on page 54. You can print them from **blueshieldca.com** or order them by contacting your Blue Shield sales representative.

Dental Member Services

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

> Dental Member Services **(888) 702-4171**
> Monday through Friday, 8 a.m. to 5 p.m. Pacific time

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

Appeals and grievance process

Members may contact Dental Member Services by phone or letter to request a review of an initial determination concerning a claim or service. Members may contact Dental Member Services at the phone number listed above. If a phone inquiry to Dental Member Services does not resolve the question or issue to a member's satisfaction, the member may submit a formal grievance at that time.

Dental Member Services can initiate a grievance on the member's behalf. The member may also initiate a grievance by submitting a letter or a completed grievance form.
The member may request this form from Dental Member Services. If the member wishes, Dental Member Services can assist in completing the grievance form. Completed grievance forms must be mailed to:

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

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

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

Dental Member Services: Eligibility, billing and account management

Blue Shield of California
Installation & Membership—Group
P.O. Box 629014
El Dorado Hills, CA 95762-9014
Attention: Dental Eligibility Changes

Phone: **(800) 325-5166**
Fax: **(877) 251-0889**

Email: LargeGroup.MemberEligibility@blueshieldca.com
Monday through Friday, 8 a.m. to 5 p.m. Pacific time

Dental Claims and Benefit Inquiry

(888) 702-4171
Monday through Friday, 8 a.m. to 5 p.m. Pacific time

How to manage your group vision benefits

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

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

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

Enrolling employees and dependents

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

> **Please note:** The effective date for an added employee or dependent must be the first day of the month following your group's benefit waiting period.

Employee status change

You are responsible for maintaining accurate eligible employee information.

- Each month you will receive a premium billing statement that includes all eligible members for the next month. Review your premium billing statement to confirm accurate eligible employee information.
- A Subscriber Change Request form (C675-1) must be completed when there is a change in status to an employee's dependents, spouse, or domestic partner.
- For terminations:
  - If using a file feed, please terminate members on the file. Note: Omissions do not generate a termination.
  - If not using an electronic file feed, note terminations on Employer Connection and contact Large Group eligibility at **LargeGroupDP@blueshieldca.com** or contact Core Priority/ShieldElite.

If your eligibility changes are submitted via an ASNI 834 file, please submit all eligibility updates via that process.

Invoice procedures

Membership changes should be faxed or mailed to Blue Shield prior to the 15th of each month to be reflected on the following month's invoice and Add/Change/Terminate Report. It is important to pay the amount shown on the invoice. Please do not subtract terminating employees' dues from the amount due as it will result in a negative balance on the next month's bill. For terminations:

- If using a file feed, please terminate members on the file. Note: Omissions do not generate a termination.
- If not using an electronic file feed, note terminations on Employer Connection and contact Large Group eligibility at **LargeGroupDP@blueshieldca.com** or contact Core Priority/ShieldElite.

The amount will then be credited on the next billing, and the account will remain current.

Open enrollment

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

Nationwide vision provider network

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

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

Vision plan information card

Each member can receive a vision plan information card for use when seeking services. The card is not required, but has useful information for both the member and the provider. Cards will be included with new enrollment materials, and additional cards can be printed from our website.

Go to **blueshieldca.com/employer** and click on Vision Plans. Or, you can call customer service for assistance at **(877) 601-9083**.

Vision ID card sample

blueshieldca.com/go
Member/Patient Services: (877) 601-9083
Blue Shield CA Insight Network
Blue Shield of California
SUSAN SAMPLE
Member ID: 123456
Group #: 1050669
Effective: 02/01/2024

Blue Shield of California is an independent member of the Blue Shield Association

Submitting a claim

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

Mail completed claim form(s) and documentation to:

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

Forms

Forms for administering group vision benefits are listed in the appendix. You can print them from **blueshieldca.com** or order them by contacting your Blue Shield sales representative.

Vision Member Services

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

Appeals and grievance process

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

Completed grievance forms must be mailed to the Vision Plan Administrator at:

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

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

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

Vision Member Services: Eligibility, billing, and account management

Blue Shield of California
Installation & Membership – Group
P.O.Box 629014
El Dorado Hills, CA 95762-9014
Attention: Vision Eligibility Changes

Phone: **(800) 325-5166**
Fax: **(877) 251-0889**

Email: **LargeGroup.MemberEligibility@blueshieldca.com**
Monday through Friday, 8 a.m. to 5 p.m. Pacific time

Vision Claims and Benefit Inquiry

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

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

How to manage your group life insurance benefits

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

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

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

Enrolling employees and dependents

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

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

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

Employee status change

You are responsible for maintaining accurate eligible employee information.

- You are responsible for maintaining Statements of Domestic Partnership, if applicable.
- You are responsible for notifying employees of their potential eligibility for:
  - Waiver of Premium upon total disability
  - Conversion upon termination of employment or reduction in coverage
  - Portability of Supplemental/Voluntary Life (for groups participating in Supplemental/Voluntary Life) upon termination of employment.

Invoice procedures

Membership changes should be faxed or mailed to Blue Shield Life prior to the 15th of each month to be reflected on the following month's invoice and Add/Change/ Terminate Report. It is important to pay the amount shown on the invoice. Please do not subtract terminating employees' dues from the amount due as it will result in a negative balance on next month's bill.

For terminations:

- If using a file feed, please terminate members on the file. Note: Omissions do not generate a termination.
- If not using an electronic file feed, note terminations on Employer Connection and contact Large Group eligibility at **LargeGroupDP@blueshieldca.com** or contact Core Priority/ShieldElite.

The amount will then be credited on the next billing cycle.

Certificate of Insurance

For group policies effective January 1, 2017, or later, a group-specific Certificate of Insurance will be included with your group policy. You will be responsible for distribution to covered employees.

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

Counseling employees on naming beneficiaries

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

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

How to submit a life or accidental death claim

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

- Proof of Death claim form (ABU1180) signed by an authorized group contact
- Original certified death certificate
- Proof of current beneficiary designation
- Original Group Life Insurance Plan Employee Enrollment form
- Any change of beneficiary forms since enrollment, if applicable

- Two months' pay stubs showing number of hours the employee has worked
- In cases of accidental death:
  - The official investigative report (e.g., police, accident, fire, FAA, OSHA)
  - Autopsy report
  - Toxicology report, and/or
  - Any medical records requested by Blue Shield

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

Please refer to your plan policy/certificate for a complete description of conditions and limitations. Mail Proof of Death claim form and documentation to:

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

How to submit a waiver of premium claim

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

The following documents are required:

- Waiver of Premium claim form (ABU1182) completed by employer, employee, and attending physician
- Attending Physician Statement of Disability (CP1012-LO)
- Proof of current beneficiary designation
- Two months' pay stubs showing number of hours the employee has worked

Blue Shield Life - Claims and Member Services
Phone: **(888) 800-2742**
Fax: **(800) 329-2742**
Monday through Friday, 9 a.m. to 5 p.m. Pacific time

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

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

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

A waiver of premium may be converted when the benefits are terminated, and at the subscriber's request. The application for conversion must be made within 31 days of termination of coverage. Only amounts of $2,000 or higher are eligible for conversion. Please refer to your plan policy/certificate for a complete description of conditions and limitations.

Mail Waiver of Premium claim form and documentation to:

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

How to submit a life or an accelerated death benefit (ADB) claim

If one of your employees becomes terminally ill, they may be eligible to withdraw an ADB benefit, subject to the following minimums and maximums:

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

The following documents are required:

- An Accelerated Death Benefit claim form (ABU1139) completed by the employer, employee and/or attending physician
- Two months' pay stubs showing number of hours the employee has worked

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

Mail Accelerated Death Benefit claim form and documentation to:

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

How to convert from group term life to individual whole life

All active employees covered under the group policy can convert to an individual whole life policy without evidence of insurability if they lose their job, their benefits are reduced, or if they are disabled.* All covered employees must be given the opportunity to request conversion information if their employment is terminated or their benefits are reduced. You should communicate this benefit to each employee. The entire amount of group term life coverage lost can be converted.

Exceptions to conversion are as follows:

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

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

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

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

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

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

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

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

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

Mail the Individual Conversion Life Insurance Policy application form to:

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

Forms

Forms for administering group life insurance are listed in the appendix. You can print them from **blueshieldca.com** or order them by contacting your Blue Shield Account Executive.

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

Appeals and grievance process

Members may contact Blue Shield Life by phone or letter to request a review of an initial determination concerning a claim or service. If the phone or written inquiry does not resolve the question or issue to the member's satisfaction, the member may submit a formal grievance at that time. The Blue Shield Life representative can initiate a grievance on the member's behalf. The member may also initiate a grievance by submitting a letter or a completed grievance form. The member may request this form from Blue Shield Life. If the member wishes, Blue Shield Life can assist in completing the grievance form.

Completed grievance forms must be mailed to the address below:

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

The Blue Shield Life plan administrator will acknowledge receipt of a written grievance within five calendar days. Grievances are resolved within 30 days. The grievance system allows members to file grievances within 180 days following any incident or action that is the subject of the members' dissatisfaction.

Please note: If an employer's health plan is governed by the ERISA (Employee Retirement Income Security Act of 1974), employees might have the right to bring civil action under Section 502(a) of ERISA if all required reviews of a claim have been completed and a claim has not been approved.

Appendix

Forms

To get copies of forms listed below or any additional forms, go to **blueshieldca.com/en/employer/forms**. There you'll find all employer and employee forms available to print at your convenience. If you need assistance, contact your Blue Shield sales representative.

Employer forms

Changes and terminations	
Employee Cancellation Transmittal Request (A36965)	Use this form to submit a monthly summary of employee terminations.

Employee forms

Additions, deletions, and other changes	
Large Group (101+) Employee Application (C15390)	Employees should complete this form to enroll in a group medical plan, group vision plan, or group term life insurance policy.

Health plans	
Attending Physician Statement of Disability (C4425)	To file for an extension of disability benefits, the employee's primary care physician must complete and submit this form to Blue Shield. In addition, employees must complete a Subscriber Statement of Disability form and the employer must fill out a Notice of Total and Permanent Disability form.
Conversion to Individual Coverage Request Form (A16170)	Employees who have held group coverage for three or more consecutive months are eligible to transfer to an individual conversion plan when they retire, leave the job, or become ineligible for group coverage.
Declaration of Disability for Over-Age Dependent Children (C3674)	Enrolled dependent children who would normally lose their eligibility under this plan solely because of age, and who are physically or developmentally disabled, may have their eligibility extended by completing this form.
Refusal or Cancellation of Personal Coverage (C13124)	Complete if the employee, spouse, domestic partner, or dependent(s) are refusing employer's health or dental plan coverages.
Request for Continuity of Care Service (C13095-540-CR)	New enrollees with qualifying conditions may be able to complete care with a non-network provider.
Subscriber Change Request (C675-1-ML)	Employees must complete this form any time they make changes to their personal information or any type of coverage changes, such as adding or deleting dependents.

Health plans	
Subscriber Statement of Disability (C12198)	To file for an extension of disability benefits, employees must complete this form. In addition, benefit administrators need to complete a Notice of Total and Permanent Disability form.

Life insurance plans	
Authorization for Blue Shield of California Life & Health Insurance Company to Disclose Personal & Health Information to a Third Party (C15625)	
Conversion to Individual Policy from Group Life Insurance (CP1020)	Employer and employee should complete this form when changing from group life insurance to individual life insurance.
Life and AD&D Beneficiary Change Request (ABU1165)	Employees should complete this form when they have additions, deletions, and other changes to their coverage.

COBRA elections	
Group Continuation Coverage (COBRA) Election (C11825-RTM) federal form	If you are self-administering or have a third-party federal COBRA administrator and you have qualified beneficiaries electing to participate in COBRA, they must complete this form.
Cal-COBRA form (C18157)	For employees who have exhausted coverage under federal COBRA and were not entitled to the maximum period or have been covered as a domestic partner and the partnership terminated.

Claims for health plans	
Subscriber's Statement of Claim (CLM-14850)	Employees should use this form ONLY when the Provider of Service does not submit their claim directly to Blue Shield. This is for Blue Shield of California plans.
Blue Shield of California Prescription Drug Reimbursement Form	Employees who are members of HMO or PPO plans that have the Blue Shield Rx Program should complete this direct reimbursement form when they did not present their ID card at a network pharmacy during the first 30 days of eligibility. Employees who are members of PPO plans should complete this form also if they have used a non-network pharmacy.
International Claim Form (C14764)	Employees should only use this form if they paid out-of-pocket for covered services while out of the country.
Blue Shield Global Core International Claim Form	Use this form if the out-of-country provider directly billed Blue Shield of California for covered services.

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

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

Life insurance plans	
Accelerated Death Benefit Claim (ABU1139)	Employer, employee, and attending physician will need to complete this form for insured persons to continue to receive life insurance coverage without payment of premiums if they become terminally ill.
Life and AD&D Waiver of Premium Claim (ABU1182)	Employer, employee, and attending physician will need to complete this form for insured employees who become totally disabled as defined in the Certificate of Insurance.
Life Insurance Proof of Death Claim (ABU1180)	Employers should complete this form for the beneficiary or dependent.

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

Employee Application quick guide

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

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

Critical fields	
Last name, first name	Full name of enrolling employee; middle initial is optional
Mailing address	Member communication, including ID card, will be mailed to this address. For HMO/POS plans, the home physical address (directly below mailing address) is required if different from the mailing address.
Full-time hire date	Date of full-time status, working 20 or more hours per week
Date of birth	Month, day, and year of birth
Sex (birth gender)	Male or female
Job title	Required if eligibility is based on job title
Social Security number	Nine-digit Social Security number (required for both employees and dependents age 42 or older)
Plan/benefit Information	Medical benefits and optional benefits chosen
Dependent information	Relationship, gender, first name, last name (if different from the enrolling employee), date of birth, and benefit option (medical/dental). If the enrollee has an over-age (older than 26) disabled dependent, a Declaration of Disability for Over-Age Dependent Children form must be included.
Signature of employee and date	Employee's signature and date on the Authorization section

Important fields	
Employer (group) name	Full business name
Department code	This is your assigned group number and is needed only if you use a department code to structure your billing units.
Home physical address	The home physical address is needed only if it differs from the mailing address.
Life insurance/AD&D amount	If graded life insurance, provide the volume of life insurance/AD&D coverage.
Home phone number	Area code and seven-digit phone number

Important fields (continued)	
Job title	Job classification of employee
Marital status	Single, married, or domestic partner
Provider information (HMO and dental HMO)	Primary care physician name, provider number, existing patient designation, name of dental center, and dental center number; applies to employee and all dependents. If left blank, Blue Shield will assign a primary care physician.
Names of primary beneficiary and contingent life insurance beneficiaries	
Race & Ethnicity (optional)	Race(s) that member(s) identifies with

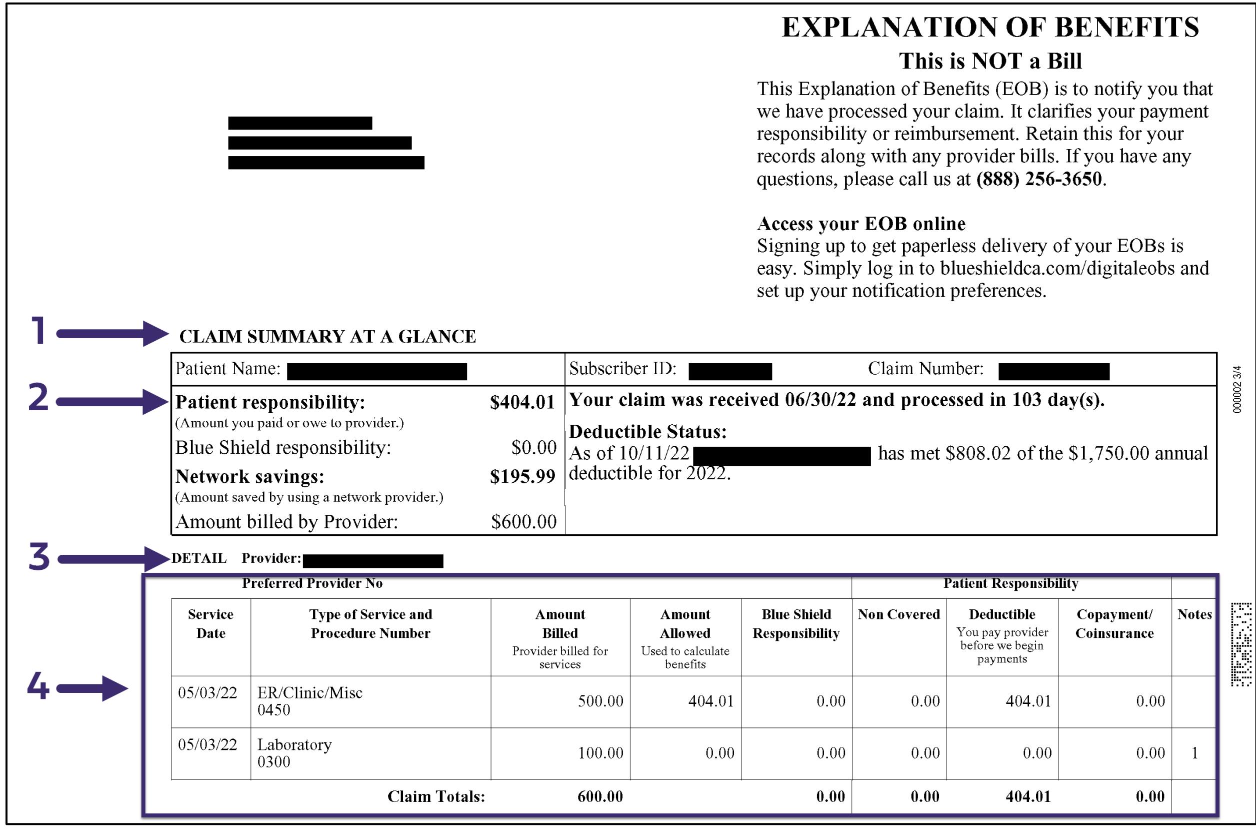
If you have questions, please contact your Blue Shield sales representative.

Explanation of Benefits

The Explanation of Benefits (EOB) provides members with clear information about their claim and benefit information including:

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

Sample EOB



EXPLANATION OF BENEFITS

This is NOT a Bill

This Explanation of Benefits (EOB) is to notify you that we have processed your claim. It clarifies your payment responsibility or reimbursement. Retain this for your records along with any provider bills. If you have any questions, please call us at **(888) 256-3650**.

Access your EOB online

Signing up to get paperless delivery of your EOBs is easy. Simply log in to blueshieldca.com/digitaleobs and set up your notification preferences.

CLAIM SUMMARY AT A GLANCE

Patient Name: Subscriber ID: Claim Number:

Patient responsibility: **$404.01**
(Amount you paid or owe to provider.)
Blue Shield responsibility: $0.00
Network savings: **$195.99**
(Amount saved by using a network provider.)
Amount billed by Provider: $600.00

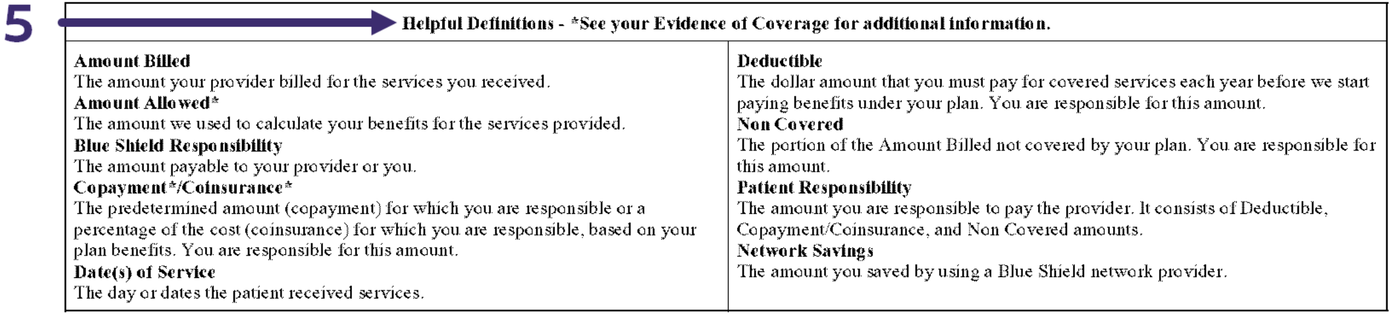
Your claim was received 06/30/22 and processed in 103 day(s).

Deductible Status:
As of 10/11/22 has met $808.02 of the $1,750.00 annual deductible for 2022.

000002 3/4

DETAIL **Provider:**

Preferred Provider No					Patient Responsibility			
Service Date	Type of Service and Procedure Number	Amount Billed (Provider billed for services)	Amount Allowed (Used to calculate benefits)	Blue Shield Responsibility	Non Covered	Deductible (You pay provider before we begin payments)	Copayment/ Coinsurance	Notes
05/03/22	ER/Clinic/Misc 0450	500.00	404.01	0.00	0.00	404.01	0.00	
05/03/22	Laboratory 0300	100.00	0.00	0.00	0.00	0.00	0.00	1
	Claim Totals:	600.00		0.00	0.00	404.01	0.00	



Helpful Definitions - *See your Evidence of Coverage for additional information.

Amount Billed
The amount your provider billed for the services you received.
Amount Allowed*
The amount we used to calculate your benefits for the services provided.
Blue Shield Responsibility
The amount payable to your provider or you.
Copayment*/Coinsurance*
The predetermined amount (copayment) for which you are responsible or a percentage of the cost (coinsurance) for which you are responsible, based on your plan benefits. You are responsible for this amount.
Date(s) of Service
The day or dates the patient received services.

Deductible
The dollar amount that you must pay for covered services each year before we start paying benefits under your plan. You are responsible for this amount.
Non Covered
The portion of the Amount Billed not covered by your plan. You are responsible for this amount.
Patient Responsibility
The amount you are responsible to pay the provider. It consists of Deductible, Copayment/Coinsurance, and Non Covered amounts.
Network Savings
The amount you saved by using a Blue Shield network provider.

blueshieldca.com/employer