



BlueCross
of California



BC Life & Health
Insurance Company

Group Administrator Manual



Solutions

Small Business Health Care Plans **at Work**



Thank you for choosing Blue Cross



September 2006

Dear Group Administrator:

Thank you for selecting Blue Cross health care coverage for your employees and their families. We appreciate your business and look forward to a long-lasting relationship with you, our valued customer.

Because your satisfaction is our primary concern, we designed this Group Administrator Manual to help you with questions about enrollment, billing, membership changes and other day-to-day administrative concerns. You'll also find helpful resources online at bluecrossca.com. Additionally, our customer service representatives are here to support you. Just call us toll free at **(800) 627-8797**.

Welcome to Blue Cross, where our mission is to help improve the lives of the people we serve and the health of our communities. We appreciate the opportunity to serve you.

Sincerely,

A handwritten signature in black ink, appearing to read "Joseph Ruiz", written over a light blue circular stamp.

Joseph Ruiz
Vice President, Group Business

Internal GAM content updated February 2007

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We're here to help 8:30 a.m. to Midnight, Monday-Friday ...

Questions about ...	Contact	Phone/FAX	Address
Premiums or Billing	Membership	Phone (800) 627-8797 FAX (805) 499-7762	Blue Cross of California P.O. Box 54630 Los Angeles, CA 90054-0630
Enrollment or Applications	Membership	Phone (800) 627-8797 FAX (805) 499-0842	Blue Cross of California P.O. Box 9062 Oxnard, CA 93031-9062
Cal-COBRA, COBRA, HIPAA and/or Medicare	Membership	Phone (800) 627-8797 FAX (805) 499-7762	
Medical Claims	Claims	Phone (800) 627-8797	Blue Cross of California P.O. Box 60007 Los Angeles, CA 90060-0007
Dental Claims	Dental Services	Phone (888) 209-7852	Dental Services P.O. Box 9066 Oxnard, CA 93031-9066
Vision Claims Out-of-Network Only	Blue View Vision Customer Service	Phone (866) 723-0515	Blue View Vision Attn: OON Claims P.O. Box 8054 Mason, OH 45040-7111
Life Claims	Life Claims	Phone (800) 552-2137	Life Claims Service Center P.O. Box 724767 Atlanta, GA 31139-1767
Pharmacy (Retail)	Blue Cross of California	Phone (800) 700-2533	Blue Cross of California c/o Prescription Drug Program (Retail Pharmacy) P.O. Box 4165 Woodland Hills, CA 91365-4165
Pharmacy (Mail Order)	PrecisionRx	Phone (866) 274-6825 Hearing Impaired Phone (800) 238-0756	PrecisionRx (Mail Order) P.O. Box 961025 Fort Worth, TX 76161-9863 www.PrecisionRx.com
Coverage while Traveling	BlueCard	Phone (800) 810-2583	n/a
Forms and Supplies	Arvato (Blue Cross Fulfillment Vendor)	Phone (877) 637-4029 FAX (800) 504-1956	www.bluecrossca.com
Section 125 Premium Only Plan (P.O.P.)	Ceridian Benefits Services	Phone (800) 767-4969	n/a
Workers' Compensation Premiums		Phone (800) 677-3252	Employers Compensation Insurance Co. P.O. Box 52772 Phoenix, AZ 85072-2772
Workers' Compensation Underwriting		Phone (800) 520-1683	Employers Compensation Insurance Co. P.O. Box 9057 Oxnard, CA 93031
Workers' Compensation Claims		Phone (805) 376-6700	Employers Compensation Insurance Co. P.O. Box 9152 Oxnard, CA 93031

Log on to www.bluecrossca.com for access 24 hours a day, 7 days a week.

We hope these self-serve options will be helpful, too ...

Internet

For comprehensive resources, please visit our Web site at www.bluecrossca.com, click on “Members” or “Employers” and then follow the prompts.

Employers

Group administrators will find two levels of time-saving resources in the Employers section of our Web site.

General Resources

Basic aids and information are easy to download and print out:

- Employee Applications and Small Group Information Change Forms
- Frequently Asked Questions
- Downloadable version of this Group Administrator Manual
- Important telephone numbers and addresses
- Additional aids and information as new updates occur

Account Access through “mybcclink”/EmployerAccess

With mybcclink, you may also enjoy password-protected access to real-time information that makes it easy to manage your Blue Cross account. Online registration is quick, easy and secure. Then you just log on to:

- Enroll new employees online
- Request ID cards
- View billings
- Change member addresses
- Cancel members

Please give us a call at **(800) 627-8797** to learn about all the ways mybcclink/EmployerAccess can streamline account administration for you.

**At this time, mybcclink/EmployerAccess is not available to groups enrolled in the BeneFits portfolio.*

Members

Private information is encrypted for security and available only through the use of a personal identification number (PIN), which the member selects as explained on the site, in order to view:

- Contract information
- Address information
- Member medical plan coverage
- Claim status
- Available doctors, specialists and hospitals, and their locations

Interactive Voice Response System

Blue Cross' Interactive Voice Response System (IVR) guides callers to a customer service representative or automated self-service options via a series of instructions and prompts. The IVR has been enhanced with voice recognition to guide the caller based on their verbal responses. Touchtone response features are also available.

To get started, have your employer group number available and call **(800) 627-8797**. The IVR will prompt you to say or enter your information. Then simply select menu option 4 to access your Group Administrator options.

Welcome to the Blue Cross Companies Small Group Services Department

If you are a Plan Member	Press 1	If you are a Health Care Provider	Press 2	If you are a Blue Cross Agent	Press 3	If you are a Group Administrator	Press 4
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As a Group Administrator, selecting Option 4 will allow you to be transferred to a dedicated customer service representative as well as select from a variety of self-service features, including:

- Verify your Paid to Date information
- Verify your employees eligibility
- Request ID cards
- Dial an extension
- Verify our phone numbers and addresses
- Request common forms to be faxed to you

About Your Billings

Premium Rates

The following information applies to Small Group employers as defined by AB1672.

Various provisions of the law govern the frequency at which benefits or rates may change for your group and subscribers within the group. We are limited in the type of changes that can be made to your group's medical premiums, including the frequency at which certain changes can be implemented. Rate changes are driven by rising health care costs and economic conditions, and it is not possible to predict when or if a change may be necessary. If you are in a rate guarantee period when a rate change might occur, your group would not receive the increase until the date your guarantee period expires.

Please note the following information to better understand the various components of your premium that are subject to change.

Rates may be affected at the group level, where all enrolled employees are affected by the change. Rates may also be affected at the individual group member level, where only a specific employee experiences a rate change. Rates at the employee level may change when dependents are added or deleted, when ages are reached that impact rates or when benefits are changed. The group and the employees within the group may also experience rate changes upon an address change or age category change.

At the group level, there are two components of your rate: **Standard Employee Risk Rates (SERR)** and **Risk Adjustment Factor (RAF)**.

- **SERR** is the base premium for each Blue Cross medical product. We will notify you 30 days in advance of any change in your SERR.
- **RAF** reflects our assessment of the risk characteristics of your particular group. The application of the RAF assigned to your group means that your actual rate may be up to 10 percent more or up to 10 percent less than the SERR for your coverage. We may re-evaluate your group, but will not change your RAF more often than once in a 12 month period. We will notify you 30 days in advance of any change in your group's RAF.

Billing Cycle

You will receive an itemized monthly invoice from Blue Cross approximately three weeks prior to the due date of the invoice. The invoice will include the due date, total premium due, past due amounts and any applicable fees. Detach the coupon from the invoice and include the premium payment in the envelope provided. Failure to include the payment coupon could result in a delay in payment processing. If your group plan includes more than one product from Blue Cross of California and/or BC Life & Health, you will receive one consolidated bill for all products.

It is the group's responsibility to check each monthly invoice for accuracy and to notify Blue Cross immediately at (800) 627-8797 if there are discrepancies. It is important that you pay the full amount of the premium listed on the invoice. Credit for retroactive deletions prior to the month for which you are being billed will not be processed. It is not necessary to submit a separate check for each product you have with Blue Cross.

Important note: Payments must be received by Blue Cross on or before the due date shown on the invoice or the premium will be considered delinquent. Your group policy is subject to termination if Blue Cross does not receive your payment when it is due. Please allow at least five days for mailing time when making your monthly payment. See your group contract for details.

Premium Payments

Non-payment of premium dues

Blue Cross reserves the right to discontinue your coverage for non-payment of your monthly premium. Failure to remit your premium payment on time will cause your Small Group policy to be terminated, effective on the first day after the expiration of the grace period. Since coverage was retained throughout your grace period, premiums are considered to be due for that period. Failure to make your premium payment does not constitute as appropriate notification to cancel your Small Group plan. Refer to the **Group Requirements and Maintenance** section; "Canceling Group Coverage" for information on how to end your Small Group plan. You are required to pay for premiums during your final month of coverage. Failure to resolve the final month's premium dues may subject your account to collections activity if the balance is not resolved.

Note: See your group contract for details.

Adjustments to Your Bill – Employee/Dependent Additions & Deletions

It is important that you pay the amount of the premium listed on your bill. Please do not send premiums for new employees being added to the group or that do not appear on the bill. These premiums will be included on a subsequent bill, after the applications have been processed and approved by Blue Cross. Please do not submit new applications or any correspondence with your bill, as this may delay processing of your payment. Send applications at the time a new employee becomes eligible to enroll. Our membership services team will process the application upon receipt and according to your group's waiting period.

Credit should not be taken for deleted employees. Premium payments must be made as billed, as payments not made 'in full' will subject your account to termination. It is highly recommended that deletions to your plan be submitted to Blue Cross as they occur for timely processing. Failure to submit eligibility change information in a timely manner could result in premium inaccuracies that may not be recoverable by the group and/or employee. Credit for terminations will be reflected on your next scheduled billing statement after the deletion(s) has been processed by Blue Cross.

Important note: Please do not submit your termination(s) with your premium payment. Please refer to the address and/or fax number on the Employee Information Change Form (#5063). Failing to pay your premium or submitting membership changes by marking on your invoice does not serve as appropriate notification to terminate an employee or dependent from your policy.

Preparing to Send Your Payment

What to include:	When to include it:
Write your group number on the face of the check	Always
Send your coupon with your check	Always
Write the amount you are remitting on the coupon	When payment includes Workers' Compensation

Where to Mail Your Payment

To ensure that your premium payment is received and processed promptly, please follow the steps listed above under "Preparing to Send Your Payment." Mail your check and the coupon only to: **Blue Cross of California, P.O. Box 54630, Los Angeles, California 90054-0630.**

Please note that this is a "lockbox" arrangement, which means that checks are automatically deposited. **Deposit of the check is not necessarily an acceptance of the payment or a guarantee of coverage.**

Pay with Check by Phone

As a convenient option, you can also call **(800) 627-8797** and pay by phone from your checking account. A \$10 administrative fee will be added to your payment if you would like to use this service.

Administrative Fees

We will assess administrative fees upon the occurrence of specific events. Once an administrative fee is assessed, it is considered due and payable with the next premium installment. The assessment of any fee does not prevent the assessment of any subsequent or additional fees to a single premium.

- ***Phone Payment Fee (for pay by check only)***
A \$10.00 administrative fee will be added to check payments via phone.
- ***Reinstatement Fee***
A \$50.00 reinstatement fee will be assessed in the event that the group's policy is reinstated after cancellation as a result of noncompliance with contract requirements, including nonpayment of premium. Payment of the reinstatement fee is a condition of reinstatement and it must be paid together with all outstanding premiums and any other administrative fees. A request for reinstatement may be approved or denied at the sole discretion of Blue Cross.
- ***Returned Check Fee***
A returned check fee of \$25.00 is assessed in the event that any instrument tendered as payment for all or part of the group's premium or for any administrative fees, is returned unpaid for any reason by the payor's bank. In the event a second returned check is received within a 12-month period, the group will be required to submit all future premiums in the form of certified funds. Remittances from groups with a certified fund requirement will be examined at our lockbox prior to posting to assure compliance with this requirement. The certified funds requirement may be removed after the group has reestablished a timely payment pattern. If a group experiences a third returned check in a 12-month period, the group's policy will be cancelled automatically.
Important note: Any check received with a stop payment will incur the same fees as a returned check and is subject to the provisions of any other dishonored check.
- ***Late Payment Fee***
A late charge of \$25.00 may be assessed on the 15th day of the month for which the premium is due. Example: The bill for a 4/1 payment is generated on 3/1. The bill will be considered late if it is not paid by 4/15 and a late charge will be assessed and reflected on your next billing statement.

Enrollment Guidelines

Eligible Employees

An employee must be included in an enrollment class for which the group has made application to Blue Cross by way of the group's Master Application and which Blue Cross accepts.

- **Full-Time**
A full-time employee must be actively engaged in the conduct of the business of the employer, with a normal work schedule of 30 or more hours per week. Only those employees whose wages are reported for tax purposes under the group's Federal Tax Identification Number via a W-2 form are considered to be eligible for enrollment.
- **Part-Time**
A part-time employee must be actively employed on a permanent, part-time basis and must be compensated for that work by the employer (subject to withholding appearing on a W-2 form). Part-time employees are not automatically included in the group's contract unless they are specifically included at the request of the employer at the time the group is formed or added at a later date (see the **Group Requirements and Maintenance** section; "Benefit Modifications"). Only those employees whose wages are reported for tax purposes under the group's Tax Identification Number via a W-2 form are considered eligible for enrollment. Employers have the option of extending coverage to employees who work either at least 20 but no more than 29 hours, or at least 15 but no more than 29 hours, per normal work-week for at least 50% of the previous calendar quarter. If the option to cover part-time employees is exercised by the employer, the option must be offered to all part-time employees.
- **Sole Proprietors/Partners/Corporate Officers**
Sole proprietors, partners and corporate officers must be actively engaged in the conduct of the business on a full-time basis, with a normal schedule of at least 20 hours per week.

Employees Residing Outside of California

Employees who live outside the state of California may also be eligible for certain coverage. **At least 51% of all employees must be employed in the State of California. Residents of Hawaii are not eligible for coverage.**

Important note: Available plans for employees residing in other states may be different than for employees residing in California. **The Blue Cross HMO plans are only available to employees who reside in the areas of California served by the Blue Cross HMO Networks.** Contact your agent or the Blue Cross Membership department for additional information.

Ineligible Employees

Temporary, substitute, contract, leased, seasonal (defined as "employees hired with a planned future termination date") or persons compensated on an IRS 1099 form substitute basis are **not** eligible for coverage.

Enrolling New Employees

A new Employee Application must be fully completed and received by Blue Cross after the date of hire and before the last day of the month following the end of the waiting period selected by the group. Applications must also be received no later than the last day of the month in which the employee is eligible. There are **no exceptions** to these requirements. Incomplete applications will not be processed, which may cause a delay in the date coverage begins for the employee. If an application is received more than 31 days past the employee's eligibility date, the employee will be considered a Late Enrollee and may be subject to delays in receiving coverage of up to 12 months (see the **Enrollment Guidelines** section; "Late Enrollees/Open Enrollment").

The employer is responsible for ensuring that sections 2 and 4 of the Employee Application (sections 3 and 5 of the BeneFits Employee Application) are completed for any employees and/or eligible dependents declining coverage.

It is recommended that applications be submitted immediately once an employee is hired. Coverage will not be secured prior to the completion of the appropriate waiting period.

You can also enroll a new employee (and dependants if applicable) via the web. Please refer to the **How to get Help** section; "Internet."

Important note: It is the employer's responsibility to ensure that applications requesting or declining coverage for each eligible employee are completed and forwarded to Blue Cross on a timely basis. Failure to do so may result in serious and extended delays in the employee receiving coverage, which may expose the employer to liability to the employee and to Blue Cross.

Please do not add premiums for new additions or enrolling a new employee. This will be reflected on a later bill.

Coverage Effective Dates

The effective date of coverage for new employees and their dependents is determined by Blue Cross and is dependent upon the following items:

- The date of hire
- The waiting period selected by the employer
- Late Enrollee classification, as defined by HIPAA
- The date the fully completed application is received and approved by Blue Cross

Effective dates are determined as follows:

- If the fully completed application is received by Blue Cross prior to the completion of the employee's waiting period, the effective date will be the first day of the month following approval and expiration of the waiting period
- If the fully completed application is received by Blue Cross after the eligibility date, but within 30 days of becoming eligible, the effective date will be the first of the month coinciding with the completion of their waiting period
- If the application is received by Blue Cross more than 30 days after the employee's eligibility date, the applicant may be considered a Late Enrollee by definition under HIPAA and the effective date may be delayed up to one year from the date of application for enrollment

Applications with missing information are considered to be incomplete and may be returned for completion.

The date upon which the fully completed application is once again received by Blue Cross will be used in determining the effective date. It is recommended that fully completed applications are received prior to the effective date requested and within the eligibility period.

Examples of effective dates for eligible employees:

	Example 1 Employee submits application within timeframe	Example 2 Employee submits application late
Hire Date	4/3/06	4/3/06
3-month waiting period	7/3/06	7/3/06
Eligibility Date	8/1/06	8/1/06
Completed Application Received	8/15/06	9/2/06
Effective Date	8/1/06	10/1/06

Examples of effective dates for eligible employees who decline coverage:

	Example 1 No qualifying event	Example 2 Employee who has experienced a qualifying event
Hire Date	4/3/06	4/3/06
3-month waiting period	7/3/06	7/3/06
Eligibility Date	8/1/06	8/1/06
Declination of Coverage Received	8/15/06	8/15/06
Employer Anniversary	3/1	3/1
Date of Qualifying Event	N/A	10/15/06
Completed Application Received	3/5/07	11/5/06
Effective Date	4/1/07	12/1/06

Enrolling Re-Hired Employees

If an enrollee's employment with the group is terminated and the employee is later rehired, certain restrictions apply. If the employee is rehired by the group *within* 30 days of termination, coverage will be resumed with no lapse upon receipt of a written request from the employer. If the employee is rehired more than 30 days after their termination date, the employee is considered to be a new employee, subject to applicable waiting periods and must complete a new Employee Application. It is the group's responsibility to notify Blue Cross immediately if an employee is re-hired and will be continuing coverage.

Eligible Dependents

Dependent coverage is not automatically included in the eligibility definitions of the Blue Cross contract. It is therefore considered an expansion of eligibility. Dependent coverage is included at the request and discretion of the employer. If the employer has extended eligibility to include dependents, it must be offered to all dependents of eligible, enrolled employees. The following persons, if not otherwise covered as subscribers in your Blue Cross plan or in military service, are considered eligible dependents:

- Lawful spouse or registered domestic partner
- Any unmarried, biological or legally adopted child (see the **Enrollment Guidelines** section; "Eligible Dependents") of the subscriber or the subscriber's enrolled spouse/registered domestic partner
- A stepchild of the subscriber or the subscriber's enrolled spouse/registered domestic partner
- A child (ward) of a subscriber or the subscriber's enrolled spouse/registered domestic partner, who is/are named the permanent legal guardian

Domestic partnership

Under existing law, health care service plans (such as Blue Cross of California) and health insurers (such as BC Life & Health Insurance Company) are required to offer coverage for the domestic partner of an employee, subscriber, insured or policyholder to the same extent and subject to the same terms and conditions provided to a dependent of those persons. AB 2208 eliminates that option, instead all health plans and insurers must cover spouses and domestic partners on an equal basis in employer-sponsored group coverage. Also, insurers must cover spouses and domestic partners on an equal basis under individual or family insurance policies.

California Assembly Bill 2208 (AB 2008), also known as the California Insurance Equality Act, amends Section 1374.58 of the Health and Safety Code, amends Section 10127.1 of the Insurance Code and creates a new Section of the Insurance Code, Section 381.5. For purposes of Section 1374.58 of the Health and Safety Code and Section 10127.1 of the Insurance Code, the term "domestic partner" shall have the same meaning as the term used in Section 297 of the Family Code.

This bill requires health care service plans and health insurers that provide hospital, medical or surgical expense benefits to provide equal coverage to employers or guaranteed associations for the registered domestic partner of an employee, subscriber, insured or policyholder to the same extent, and subject to the terms and conditions provided to a spouse of an employee or subscriber if spousal benefits are covered.

Effective January 1, 2005, every Small Group was automatically provided with registered domestic partner benefits.

Please note: If required documentation is not provided with the application, the application will be held pending. If this occurs, it may affect the actual effective date of coverage. Failure to respond to our request for this documentation will result in us returning the application.

Where an eligible employee requests self-coverage but chooses to decline coverage for a domestic partner, the employee must complete the declination on the Employee Application.

If a domestic partnership terminates, the employee must notify the group administrator and provide a signed, notarized copy of the Affidavit of Termination of Domestic Partnership within 30 days of the termination. A new domestic partner may not be enrolled under this plan until six months after the previous domestic partner was removed from the plan.

MORE ABOUT ENROLLMENT...

What is a “Domestic Partner”?

Domestic Partner is defined in Family Code Section 297 (which was established by AB 205 in 2003) as follows:

Family Code Section 297

(a) Domestic partners are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring.

(b) A domestic partnership shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State pursuant to this division, and, at the time of filing, all of the following requirements are met:

- (1) Both persons have a common residence.*
- (2) Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.*
- (3) The two persons are not related by blood in a way that would prevent them from being married to each other in this state.*
- (4) Both persons are at least 18 years of age.*
- (5) Either of the following:*
 - (A) Both persons are members of the same sex.*
 - (B) One or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both of the persons are over the age of 62.*
- (6) Both persons are capable of consenting to the domestic partnership.*

(c) "Have a common residence" means that both domestic partners share the same residence. It is not necessary that the legal right to possess the common residence be in both of their names. Two people have a common residence even if one or both have additional residences. Domestic partners do not cease to have a common residence if one leaves the common residence but intends to return.

In order for an opposite-sex domestic partner to be eligible for enrollment in a Small Group plan, they are subject to having the subscriber and domestic partner complete a Blue Cross of California affidavit.

Is a Domestic Partnership a same sex relationship or an opposite sex relationship according to Family Code Section 297?

Family Code Section 297 states that same sex domestic partners (age 18 and older) can legally register as domestic partners. Persons of opposite sex may not constitute a domestic partnership unless one or both of the persons are age 62 or older and are eligible for Social Security.

*Blue Cross **will** cover opposite sex domestic partners under the age of 62 unless your employer opts not to. If your group chooses not to cover **opposite** sex domestic partners **under** the age of 62, you must submit a statement of such on company letterhead signed by an officer of the company.*

Does the requirement to provide health coverage to an employee's domestic partner extend to the children of the domestic partner?

Yes, the children of the domestic partner will be covered on the same basis as other eligible dependents. The law requires that coverage be provided to a registered domestic partner to the same extent and subject to the same terms and conditions as provided to a spouse. If the plan covers children of the employee's spouse, it must also cover the children of an employee's legally registered domestic partner.

Can groups opt out of this, such as religious groups?

No. The law requires that health plans and health insurers include domestic partner coverage in their group contracts and policies, and makes no exceptions for contracts or policies issued to religious employers or for any other type of employer.

Children's Age/Qualification Criteria

All dependent children, stepchildren and wards must meet the following age/qualification criteria to be eligible for coverage:

- Unmarried children of the subscriber or the subscriber's enrolled spouse/registered domestic partner, up to their 19th birthday.
- Unmarried children of the subscriber or subscriber's enrolled spouse/registered domestic partner, from the 19th to the 24th birthday, who qualify as dependents for federal income tax purposes and who are full-time students (for 12 or more credits) attending an accredited college, university, vocational or technical school. *Certification of the child's full-time student and dependent status is required annually until age 24.*
- Unmarried children who are enrolled in the employer's Blue Cross Small Group plan prior to reaching the applicable limiting age for a dependent child, who depend on the subscriber for support and are unable to work due to diminished mental capacity or physical handicap. A physician must certify this disability in writing. This certification must be received by Blue Cross within 30 days of reaching the applicable limiting age and not more frequently than annually thereafter.

Application for coverage for a child must be submitted to Blue Cross within 30 days of the child's eligibility for coverage. Coverage of a child will begin on the first day of the month following receipt of the completed and approved Employee Application.

Important note: If both parents are covered subscribers, their children may be covered as family members of either, but not both subscribers.

Enrolling Eligible Dependents

Type of Dependent	Application for coverage or declining coverage must be received:	And must include (if requesting coverage):
<p>New Spouse or New Domestic Partner Coverage will begin on the first day of the month following receipt of required documents, including: <u>New Spouse</u>: No documentation required <u>Same Sex New Domestic Partner</u>: No documentation required <u>Opposite Sex New Domestic Partner</u>: BCC Affidavit</p>	Within 30 days of new marriage or new domestic partner registration	Employee Application Legal documentation of marriage or domestic partnership (see left)
<p>Newborn Child Coverage of newborns is automatic only for the first 31 days following birth. Employees must initiate a request to enroll newborns. This can be done by phone <i>within</i> the first 31 days following birth. After 31 days, an Employee Application must be completed. Otherwise, coverage terminates at the end of the 31-day period. Payment of claims for birth-related expenses is not an indication of continued coverage. The employee must initiate the addition of a new dependent.</p>	Within 31 days of birth	Verbal or written notice by calling Membership (800) 627-8797
	After 31 days of birth	Employee Application
<p>Adopted Child A child who is in the process of being adopted is considered a legally adopted child if Blue Cross receives legal evidence of intent to adopt or notification of physical custody and the subscriber or spouse/domestic partner has the authority to control the health care needs of the child or has assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption.</p>	Within 30 days of adoption or the right to control health care	Employee Application Legal evidence of authority to control the health care needs of the child
<p>Stepchild A child of the subscriber's spouse or registered domestic partner.</p>	Within 30 days of marriage or new domestic partner registration	Employee Application Legal documentation of marriage or domestic partner registration
<p>Ward of a Permanent Legal Guardian An unmarried child (ward) of a subscriber or the subscriber's enrolled spouse/domestic partner who is named the permanent legal guardian by a final court decree or order will be considered an eligible dependent child, subject to all rules and age limitations that apply to an eligible dependent child.</p>	Within 30 days of issuance of the final court decree or order of legal guardianship	Employee Application "Letter of Guardianship" form from the court, showing the filing date and court seal.
<p>Late Enrollee Dependents Dependents are considered Late Enrollees if coverage is not requested within the required timeframe:</p> <ul style="list-style-type: none"> • If Blue Cross receives fully completed application after the eligibility date, but within 30 days of dependent becoming eligible, coverage can be effective the first of the month following approval of the application • If application is received more than 30 days after eligibility date, dependent may be considered a Late Enrollee under HIPAA, and effective date delayed up to one year from application date. 	During the group's open enrollment period (Blue Cross anniversary) Prior to conditions which would otherwise cause a dependent to be a Late Enrollee	Employee Application Proof of qualifying event

Applications with missing information are considered to be incomplete and may be returned for completion. The date upon which Blue Cross once again receives the fully completed application is used in determining the effective date. Fully completed applications must be received prior to the effective date requested and within the eligibility period.

Declinations

New employees not electing coverage or existing employees who choose to discontinue coverage under the employer's Blue Cross Small Group policy must complete sections 2 and 4 of the Employee Application. The application must be received by Blue Cross after the hire date and before the last day of the month following the end of the waiting period selected by the group. It is the employer's responsibility to ensure that applications declining coverage be received by Blue Cross within the same time frame as employees requesting coverage (see "Enrolling New Employees" subsection). Depending upon the reason the employee chose to decline coverage, they may be eligible to reapply at a later date. If an employee applies after their eligibility period has expired and no declination has previously been received, they may be considered a Late Enrollee and subject to Late Enrollee guidelines.

Late Enrollees/Open Enrollment

If a new Employee Application is received by Blue Cross more than 31 days after becoming eligible, the subscriber and eligible dependents will be considered Late Enrollees and will be required to wait until the group's anniversary date to obtain coverage. This is known as "Open Enrollment."

The process for Open Enrollment is the same as if the group were adding an employee upon its anniversary date. All employees and/or eligible dependents who previously declined to enroll, who wish to enroll, must complete an Employee Application (form 3345). The application must be received within 30 days of the group's anniversary date. The group anniversary can be verified by contacting Customer Service.

Please consult the Combined Evidence of Coverage and Disclosure Form and/or Certificate for exceptions due to Special Enrollment Periods.

Pre-existing Conditions

A pre-existing condition is an illness, disease or physical condition for which medical advice, diagnosis, care or treatment, including the use of prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the earliest of either the first day of the waiting period or the date the member's coverage begins.

Under the terms of your Blue Cross Small Group policy, new employees and their dependents, if any, may be subject to pre-existing condition limitations and exclusionary periods. Pre-existing condition limitations and some exclusionary periods do not pertain to employees and their dependents if an HMO plan is selected. Pre-existing condition limitations and exclusionary periods will apply, however, with any PPO plan selected, as well as certain dental plans.

Please refer to your Combined Evidence of Coverage and Disclosure Form and/or Certificate for a detailed explanation of pre-existing conditions, limitations and exclusionary periods.

Where to Submit Applications

All employee applications requesting or declining coverage should be mailed or faxed to:

Mail: **Small Group Services**
 Blue Cross of California
 P. O. Box 9062
 Oxnard, CA 93031-9062

Fax: **(805) 499-0842**

Internet: **mybcclink or EmployerAccess at www.bluecrossca.com**

Employee Application Tips

- Use black or blue ink and print **clearly and legibly**
- Include your Small Group number at the top of the application
- Make sure all required areas of the form are completed
- If the HMO plan is selected, a PMG or IPA and office number is required
- If Dental Net is selected, a dental office and office number must be selected
- **All** information in Section 3 must be completed
- Social Security or ID number(s) are required
- The employee must either enroll or decline coverage for all eligible dependents
- Information on previous coverage is critical; be sure to submit proof of prior coverage (if applicable) and provide a copy of a Medicare ID card (if applicable)
- The last page of the application must be signed and dated by the employee and the employee's spouse. If the employee has a registered domestic partner, they must also sign and date the application if applying for coverage
- If Life insurance is requested, a beneficiary **must** be named

Enrollment Actions Guide

Action	How this action can be done:				Comments
	Internet Mybcclink/ EmployerAccess	Employer Application	Employee Application	Small Group Information Change Form (#5063)	
Add a new employee and/or dependents to the plan	X		X		Additional documentation may be needed depending on type of dependent
Add dependents for an existing employee	X		X		
Decline coverage for an employee and/or dependents			X		Sections 2 & 4 of the Employee Application must be completed
Change plans for employees or dependents who already have coverage			X		Changes may only be requested on the group's anniversary date
Terminate an employee and/or dependents from the plan	X			X	Notify Blue Cross immediately upon termination
Discontinue coverage for employees and/or dependents who still remain eligible under the plan	X		X	X	Employee Application must be completed to avoid delays if coverage is selected at a later date
Change an employee's address (note: may impact employee's rate)	X		X	X	Can also be done over the phone by the employee directly
Provide notification of a COBRA or Cal-COBRA qualifying event for an employee and/or dependents already enrolled in the plan				X	Complete the Small Group Information Change Form
Remove a subscriber from Federal COBRA	X			X	Complete the Small Group Information Change Form
Change employer's address	X	X		X	You may also submit a written request on the employer's letterhead, signed by owner/officer of the company

Important Note about Internet Capabilities: For your protection, registration in mybcclink (EmployerAccess) for Small Group employers is necessary before you will be able to perform some of the online functions checked above in the Internet column. Registration is quick and easy, giving you convenient, password-protected access to administer your group's account. See the **How to get Help** section for details.

Membership Changes

Deleting Employees from the Plan

The Small Group Information Change Form should be used for deleting employees from the plan. Employees may be deleted from the plan due to termination of employment, ineligibility for coverage under the plan or when the employee does not wish to continue coverage regardless of his/her employment status and/or eligibility. The employee must be cancelled from the plan if the following situations occur:

- Employment is terminated
- An eligible full-time employee changes to a part-time employee and the group's plan does not cover part-time employees
- An employee is on leave of absence (medical and/or personal) and the time period that the employer covers employees on leave has expired
- An eligible part-time employee's work is permanently reduced to less than the minimum number of hours per week, based on whether the employer has elected to offer coverage for those who work:
 - 15 – 29 hours per week, or
 - 20 – 29 hours per week
- An eligible employee becomes ineligible by converting to one of the following types of employee: temporary, substitute, seasonal, leased or contract, or whose compensation is reported on an IRS 1099 form
- An employee otherwise becomes ineligible to participate in the plan
- The employee no longer wants to continue Federal COBRA coverage

Deleting Terminated Employees

Section 1 of the Small Group Information Change Form should be filled out completely. Please include employee or dependent names, identification number, name, termination date, request for COBRA or Cal-COBRA and the qualifying event for termination. If Cal-COBRA is requested, be sure all the necessary information is included. Due to the notification requirements mandated by Cal-COBRA and COBRA, it is recommended that terminations be reported to Blue Cross as they occur. It is not necessary to delay this notification until you are preparing your monthly payment. Blue Cross of California must be notified on a timely basis of employment termination. Notice must be made in writing by completing the Small Group Information Change Form. The notice should be faxed to **(805) 499-0842** or mailed to:

**Blue Cross of California
P.O. Box 9062
Oxnard, CA 93031-9062**

If you are faxing the documentation, it is not necessary to mail the originals. **Please do not include the Small Group Information Change Form or any correspondence with your monthly payment.** Employers are obligated by law to allow employees to remain on the plan until their employment has been terminated. The employee will be deleted from the plan effective the last day of the month in which notification is received. Timely notification of terminations is required to assure that coverage does not extend beyond the month that termination occurred and to comply with COBRA and Cal-COBRA notification requirements. Delayed notifications will prevent timely cancellation of coverage in addition to providing continued coverage for otherwise ineligible members.

Important note: Due to state and other regulations, retroactive policy terminations are not allowed. A member whose employment has been terminated **must be cancelled** from the group. If the employee has elected to continue coverage under COBRA, they must still be cancelled from the plan. Once Blue Cross has been notified of the COBRA election, the member will be enrolled under the group's COBRA benefits. **The employer is obligated under law and by contract to Blue Cross to notify employees of termination of coverage and of any rights to continue coverage. Failure to do so exposes the employer to liability to the employee and to Blue Cross. Please do not delete any premiums for these cancelled members. A credit for the deletion will be reflected on future billing.**

Retroactive terminations will not be accepted.

Deleting Employees Who Remain Eligible but Discontinue Coverage

Please complete the following information on the Small Group Information Change Form or submit a request on company letterhead: an identification number, Employee and/or dependent(s) names, which coverage is being deleted, reason for coverage cancellation and effective date.

Please remember sections 2 and 4 of the Employee Application must be completed for those employees who are still employed but canceling coverage. This is in accordance with California State Law AB1672.

The employer must complete section 2 of the Small Group Information Change Form or provide written instructions on company letterhead and submit it with the Employee Application to Blue Cross. The employee's coverage will be deleted as of the last day of the month in which the completed application declining coverage is received.

Employees who remain employed and are already enrolled in the plan and then choose to discontinue coverage may be considered a Late Enrollee should they wish to re-start coverage at a later date. If the employee changes his/her mind later and re-applies for coverage under this plan, the effective date may be delayed until the group's anniversary date. The employee would have to reapply at that time.

Deleting COBRA Members

COBRA members are subject to the same grace period as the group. It is the responsibility of the group to delete the COBRA member in a timely manner if payment is not received within the specified grace period. Retroactive terminations will not be accepted beyond the original grace period.

COBRA-Eligible Dependents

Should a dependent become eligible for COBRA, section 1 of the Small Group Information Change Form should be completed. A dependent is eligible when there is a divorce, death of a subscriber, a dependent child becomes overage or the subscriber becomes eligible for Medicare.

It is the employer's responsibility to notify Blue Cross in a timely fashion of changes in group size that cause changes in the group's Medicare and COBRA status.

Employees Turning 65

Medicare is the primary payer for employees age 65 or older in employer groups with less than 20 employees (based on 50% of the working days in the preceding calendar year). Blue Cross is not a supplement to Medicare. Please have employees turning age 65 consult their Combined Evidence of Coverage and Disclosure Form/Certificate or contact Customer Service to discuss their coverage options prior to becoming eligible for Medicare. **It is also recommended that the member contact the Social Security Administration prior to turning 65.** Please be advised that premium rates are affected when the member turns 65.

Extension of Benefits

The plan provides for a limited extension of benefits if coverage terminates, the member is totally disabled and certain other criteria are met. The extension (up to 12 months) covers only the totally disabling condition and is subject to review every three months. An extension of benefits must be requested in writing or by calling Blue Cross Customer Service within 90 days of the cancellation of coverage (see the **Group Requirements and Maintenance** section; "Continuation of Coverage").

Overage Dependents

The group plan allows for the coverage of unmarried dependent children up to the age of 19, after which they are no longer eligible for benefits under the plan. Coverage will be cancelled on the first day of the month following their 19th birthday. Coverage for unmarried dependent children may be extended beyond the 19th birthday to the child's 24th birthday, provided certain conditions are met and documentation is provided to Blue Cross by the parent. Prior to the dependent child's 19th birthday and annually thereafter up to the 24th birthday, the parent will be asked to certify whether the dependent is eligible to continue under the plan. Certifications cease once Blue Cross has been notified that the dependent is no longer eligible to participate under the plan or when the parent does not complete the certification.

Coverage may be continued if either of the following conditions exists **and** proper documentation is received, as outlined below:

Status	Documentation Required
Full-Time Student: attending an accredited college, university, vocational or technical school, carrying 12 or more credits/units concurrently, and qualifies as a dependent for federal income tax purposes.	Letter from employee certifying these conditions have been met.
Incapable of self-sustaining support due to physical handicap or diminished mental capacity.	Certification from attending physician that dependent is incapable of self-sustaining support due to physical handicap or diminished mental capacity.

Balancing Employee Choice and Employer Control

An Overview of Comprehensive Coverage

Your health coverage package can be built anyway you want to offer your employees complete peace of mind, and wrap it all up with one consolidated invoice.

- **Medical coverage** – start with a strong foundation
- **Dental coverage** – add even more value
- **Vision** – build a clearly superior benefits package
- **Life** – provide security and peace of mind
- **Workers' Compensation** – fulfill state requirements and save money at the same time

Medical Coverage

Every business has different kinds of needs. Blue Cross of California and BC Life & Health Insurance Company offer several medical plan solutions.

EmployeeElect

Standard employee participation and employer contribution requirements apply (see page 28), with flexibility for future changes and 16 plans to choose from.

- 12 PPO plans and 4 HMO plans to help you find the ideal balance between cost and benefits. (Please note: The Power Select HMO plan is not available in conjunction with any other HMO product(s).)
- Administrative ease with integrated billing and customer service make it easy to offer as many different plans and types of coverage desired
- Financial control give you three ways to set your monthly contribution to your employees' medical premiums

EmployeeChoice

For employers who want the option to offer an HMO from another carrier for your employees, consider the EmployeeChoice program.

- 5 popular Blue Cross plans
- At least 5 employees must enroll in the Blue Cross plans

Except for this additional HMO flexibility, EmployeeChoice has the same employer contribution requirements (see page 28), the ability to integrate Workers' Compensation and add Life, Dental and Vision, and the opportunity to receive special discounts and savings, just like EmployeeElect.

BeneFits

BeneFits is a unique solution that makes coverage easier to understand, easier to afford and easier to qualify for employers who are especially cost-conscious or offering insurance benefits for the first time.

- 5 progressive plans
 - Four targeted PPOs and one HMO starting with basic coverage and adding more benefits from plan to plan - including two comprehensive plan options and one plan that even has some built-in dental and vision benefits
 - All-in-one package – you decide how many plans to offer your employees
- More affordable rates
- Lower employee participation and employer contribution requirements (see page 28)
- All the advantages that Blue Cross coverage helps every employer enjoy – guarantee issue, potential tax savings for your company, 12-month rate guarantee, as well as discounts and savings when Specialty products are purchased with Medical (Dental, Vision, Life, Workers' Compensation) and more

More information about the BeneFits portfolio is available online at mybccbenefits.com/EmployerAccess.

Dental Coverage

Employers offering dental coverage for their employees have something to smile about by adding value to their benefits package. Flexible financing allows the employer to set monthly contributions in one of two ways: Traditionally (employers pays at least 50%) or with a fixed dollar contribution (employer pays \$15 or more in \$5 increments).

PPO Dental Plans Highlights

- Access to quality care at discounted fees
- Freedom to choose providers outside our network
- Eight plans with a range of deductibles, coinsurance levels, annual maximums and orthodontic benefits
- Pricing based on group size with our Silver, Gold and Platinum plans – the larger the group, the lower the rate

HMO Dental Plans Highlights

- Self-selection of participating dentist (provider) from one of our HMO networks (out-of-network services are not covered)
- Provider coordinates care including specialist referrals
- Low out-of-pocket costs with no deductibles or annual maximums
- No waiting periods on preventive, diagnostic and minor restorative services
- Orthodontic service for children and adults

Other Dental Coverage Options

Voluntary Dental Plans Highlights

- Employers are not required to contribute to employees' monthly premiums
- Employees can pay up to 100% of the premium cost
- Two or more eligible employees must be enrolled in Blue Cross medical coverage
- Only three employees or 25% of eligible employees (whichever is greater) must enroll in Voluntary dental coverage
- Includes two plan choices – an HMO and a PPO
- Preventive and diagnostic care begin immediately after approval

SmileNetSM Dental Discount Program

SmileNet is not an insurance plan. It is an inexpensive and easy-to-use dental discount program that can help members (your employees) to save 10-15% on dental services and provides access to most of the dentists in our Dental PPO network.

Any number of your employees can join. There are no participation requirements and employers can choose to pick up part of the cost, all of the cost or none of the cost. SmileNet can be offered as a standalone dental program or with any of our medical plans (as long as no employees are covered by one of the traditional Blue Cross dental plans).

SmileNet members can choose from most of the dentists in the Blue Cross Dental PPO network and get dental services at Blue Cross-negotiated rates. There are no traditional office visit copays. Payment is due when services are rendered. Your employees can get dental services when they want, as often as they want.

**SmileNet cannot be offered within the Hospital BeneFits Preferred Plan. However, it can be sold with the other plans in the BeneFits portfolio, as long as it is not offered along side any other insured dental product. Employer contributions to a discount program may have tax implications. Consult your tax advisor.*

Vision Coverage

Employers can offer the strongest vision coverage in sight with Blue View VisionSM. Blue View Vision offers your employees a cost-effective, comprehensive plan that meets their vision needs, including:

- Convenient eye exams
- Fast delivery of eyewear
- Statewide network, including an extensive selection of ophthalmologists and optometrists as well as LensCraftersSM, Target Optical, Sears Optical and most Pearle Vision locations
- 15-40% retail savings, even beyond plan benefits on unlimited purchases of extra pairs of eyewear, non-prescription sunglasses and other popular accessories
- Frame allowance covering up to 75% of manufactured frames

Life Coverage

Life coverage is an important, inexpensive way to help your employees protect their families' financial future. As an employer, you can regain peace of mind by offering several types of coverage to your employees, including Basic Term Life, Dependent Life and Supplemental Life. Life coverage at-a-glance encompasses:

- Basic Term Life coverage is available from \$15,000 to \$250,000 and includes Accidental Death & Dismemberment (AD&D) benefits
- Groups that offer \$25,000 or more of Basic Term Life also receive a valuable, free Employee Assistance Program (EAP) to help enrolled employees get referrals for counseling, treatment and therapy
- Two Dependent Life coverage options (employer contribution not required)
- Supplemental Life (employer contributions not required)

Composite Rates: All new groups of 11+ enrolling employees automatically get the advantage of Composite Life rates. This means that employers receive a single rate per \$1,000 of Life coverage, regardless of the age or sex of those enrolling.

Save with Life

When employers purchase medical and \$25,000 or more of Life at the same time, you receive up to 1% savings on your medical premiums (.90 is the best Risk Adjustment Factor available), making Life insurance more affordable than ever.

Save Even More with Life and Dental

Purchase both \$25,000 or more of Life coverage and any insured Dental plan(s) at the same time, and receive 6% savings on your Life premium and 6% on your Dental premium (SmileNet Dental Discount Program does not qualify).

Workers' Compensation

Blue Cross and Employers Compensation Insurance Company (ECIC) have joined forces to integrate Medical coverage and Workers' Compensation in one convenient, cost-effective program that includes Medical benefits and Workers' Compensation coverage.

Advantages of Integration with Medical

In addition to substantial savings – 10% automatic discount on the Workers' Compensation portion of your integrated premium – employers and employees received many other advantages:

- One managed care provider network for both personal health and Workers' Compensation coverage
- Employees' network family physicians can treat both personal illness and work-related injuries and refer to specialists when necessary
- Easy administration through one consolidated bill and point of contact

Nearly half of Workers' Compensation claims are Medical expenses. By reducing Medical expenses using the lower Blue Cross-negotiated network fees, employers also have the potential for long-term savings on Workers' Compensation premiums.

Integrate and Save

When you integrate Workers' Compensation from Employers Compensation Insurance Company with your Blue Cross Medical coverage, you receive:

- **10% discount automatically** on the Workers' Compensation portion of your integrated bill
- **Potential additional savings** on the Medical portion of your integrated bill if you qualify (underwriting required)

Group Requirements and Maintenance

Accuracy of Information

In order for Blue Cross to effectively administer benefits under your group policy, you must submit timely, accurate information on any eligibility changes, including new employee or dependent additions, changes in plans, terminations, address changes, leaves of absence, COBRA and Cal-COBRA notices, Medicare eligibility and individuals turning age 65. It is also the employer's responsibility to notify Blue Cross of changes that affect the group including, but not limited to, an address change for the company, change in ownership, change in group administrator, an acquisition or merger of or by another company or business entity, or a change in the number of persons employed by the company when such a change may affect the group's COBRA, Cal-COBRA or Medicare payee status. Information regarding these and other events must be submitted within designated time frames as outlined in your Combined Evidence of Coverage and Disclosure Form/Certificate.

Important note: Failure to provide updated eligibility information may result in delays in coverage or premium inaccuracies that may not be recovered by the group or the employee.

ID Cards and Certificates

All enrolled employees will receive a Combined Evidence of Coverage and Disclosure Form (EOC)/Certificate and Blue Cross Identification Cards. If these items are sent directly to the employer, it is the employer's responsibility to distribute them to the enrolled employees.

Employees will receive identification cards showing their name and coverage selected. Cards are not automatically generated for each dependent. PPO plan members will have ID cards listing only the Employees name, even if other family members have coverage. This card is valid for all covered members. Some HMO ID cards are available in dependants' names depending on the doctor selection. Additional cards can be ordered through Membership. If an identification card is lost, misplaced or destroyed, replacement cards may be ordered online, by calling customer service or using the self-service features on the automated phone system.

If an employee selects the HMO plan and the employee's spouse or dependent(s) selects a different HMO Participating Medical Group (PMG) or Independent Practice Association (IPA) than the employee, a separate card will be issued displaying the spouse's or dependent's PMG or IPA.

Employee Participation Requirements

A certain percentage of employees must participate (enroll) in the Blue Cross coverage offered by the employer.

To calculate employee participation, start with the total number of employees, including owner(s). Next, subtract allowable waivers (e.g., employees who already have coverage under Medicare/MediCal/Military or as a dependent on a spouse's or parent's employer-sponsored group plan and, for EmployeeChoice only, those who enroll in the other HMO plan sponsored by their employer*). Those who remain are the total number of eligible employees. Last, divide the number of eligible employees by the total number of employees. The resulting percentage indicates the group's participation.

MORE ABOUT GROUP REQUIREMENTS AND MAINTENANCE...

Examples show how participation might be calculated for small businesses (including owner):

	EmployeeElect	EmployeeChoice*	BeneFits
Total Employees	30	15	8
Waive those who don't participate for allowable reasons			
-employees already has coverage through MediCal	-1	X	-1
-employees already has Military coverage	-1	X	-1
-employees covered by spouse's employer group plan	-4	-1	X
-employees covered by parent's employer group plan	-2	-3	X
-employees covered by other employer-sponsored HMO* plan	X	-1	X
Eligible Employees	22	12	6
Subtract those who don't participate for other reasons			
-employees who want to keep existing Individual plan instead	-1	-1	-1
-employees who just don't want to participate	-3	-2	-1
Eligible Enrolling Employees	18	9	4
Participation Percentages	82%	75%	66%

**For EmployeeChoice, please note that a minimum of five (5) employees must enroll with Blue Cross, and Blue Cross has no influence whatsoever on the participation levels required by the carrier who provides the employer's other HMO plan.*

Participation Percentages must be:

- 75% for EmployeeElect and EmployeeChoice* Medical plans and all Specialty products (Dental, Life and Vision)
- 60% for BeneFits Medical plans

The number of eligible enrolling employees is divided by the number of eligible employees to yield the group's participation percentage. In these examples, each of these groups would qualify for coverage. Groups must maintain their participation percentages or the group is subject to non-renewal.

Special Provisions

- If the employer pays 100% of employees' Medical, Dental and/or Life premiums, then 100% of eligible employees must participate
- To offer Voluntary Dental for a group of 2-50 that has Medical coverage, at least 25% or three eligible employees (whichever is greater) must enroll in our Voluntary Dental HMO and/or PPO plans
- Supplemental Life participation levels vary by group size: groups of 2-3 must have 100% participation; in groups of 4-10, at least 3 must participate; groups of 11-50 must have 25% participation

Contribution Requirements

Employers can share monthly premium costs with their employees. The employer chooses a contribution option and pays at least a minimum amount of each employee's monthly premium (dependent contributions are optional). Employees cover any remaining premium balance themselves through payroll deductions.

Type of Coverage	Employer Contribution Options		
	Traditional (percentage applied to all plans employees are enrolled in)	Percentage & Plan* (percentage based on the price of one designated plan only)	Fixed Dollar (dollar amount, in \$5 increments, applied to all plans employees are enrolled in)
Medical Plan Portfolios/Programs			
EmployeeElect	50% to 100%	50% to 100%	\$100 or more
EmployeeChoice	50% to 100%	50% to 100%	\$100 or more
BeneFits	25% to 100%	25% to 100%	\$50 or more
Dental	50% to 100%	N/A	\$15 or more
Vision	50% to 100%	N/A	N/A
Life	25% Minimum Employer Contribution		

**Percentage & Plan option: only available for Medical; premium price of the Basic PPO Plan from BC Life & Health Insurance Company cannot be designated as the basis for the employer's contribution.*

Anniversary Dates

An employer's anniversary date is the month and day on which the group's policy became effective and coverage commenced. **The group's anniversary date cannot be changed.** The group's anniversary date is important because there are certain actions and changes that can occur only on that date. These activities include the following:

- Change from one type of plan to another already offered by the group
- Request addition of part-time employees as a class of eligible employees
- Request a review of the group's Risk Adjustment Factor
- Request to change the employer's contribution approach
- Request to add employees and/or dependents who previously declined coverage

If your original effective date is the 15th of the month, your anniversary date is the 1st of the following month (e.g. if your original effective date is January 15th of one year, then your anniversary date is February 1st each year after that).

Employer Waiting Periods

The waiting period is selected by the employer and is the period of time that must pass between an employee's hire date and the date on which they are eligible to enroll or decline to participate in the employer's benefit plan. The employer can choose a one, two, three, four, five or six month waiting period or no waiting period. The first available effective date for new employees is the first day of the month following or coinciding with the month in which the waiting period expires.

It is possible for an employer to select two different waiting periods to accommodate various classes of employees within the group. In order to do so, however, there must be a clear definition and distinction of the class of employees eligible for each type of waiting period. A second waiting period cannot be established without these definitions. Employee Applications must be submitted with instructions as to which waiting period will apply. Blue Cross may require verification of the employee's status relative to the requested waiting period. Enrollment requests for employees who do not meet the definition of eligible employees for a specific type of waiting period will not be processed.

New groups may request a change in their waiting period six months from the date the policy became effective. Requests to change the group's waiting period may be made once every 12 months. The request must be made in writing on the group's company letterhead and must be signed by an owner/officer of the company. The change, if approved, will be effective on the first of the month following receipt of the employer's request.

The waiting period is applied to all employees within the group. No exceptions can be made to this requirement. Blue Cross does not waive the waiting period for any eligible employee. Blue Cross will not honor any special hiring arrangements that differ from the existing waiting period. Waiting periods will not be changed retroactively. Employees hired before the effective date of the new waiting period will be subject to the previous waiting period.

Converting Part-Time Employees to Full-Time Employees (and vice versa)

Coverage for part-time employees is considered an extension of eligibility and is offered at the discretion of the employer. If an employer has elected not to extend benefits under the group plan to part-time employees, part-time employees may not enroll. Prior part-time employees who become full-time employees are eligible to enroll as of the date they become a full-time employee. A full-time employee is defined as any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the employer with a normal work week of at least 30 hours (at the employer's regular place of business) and who has met any applicable waiting period requirements. The same enrollment guidelines and procedures apply as if the employee were a new employee, including the requirement that a completed Employee Application must be submitted within 30 days of becoming a full-time employee.

Enrollment of the employee is subject to the waiting period established by the employer. The waiting period commences on the date the employee begins full-time employment.

Prior employment on a part-time basis is not credited towards the waiting period unless the employee has worked for the employer continuously for a minimum of one year.

It is the employer's responsibility to accurately inform Blue Cross of the employment status of their employees in a timely fashion. When a full-time employee becomes a part-time employee and the group policy does not extend coverage to part-time employees, the employee is no longer eligible for coverage as of the first day of the month following the new part-time status. It is the employer's responsibility to notify Blue Cross of this change in status in a timely fashion via the Small Group Information Change Form. Once coverage ends, the employee may have the option to continue coverage under either COBRA or Cal-COBRA benefits (see the **Group Requirements and Maintenance** section; "Continuation of Coverage").

Canceling Group Coverage

Should you choose to discontinue your group coverage, please notify Blue Cross immediately in writing. Written notification must appear on company letterhead and be signed by an owner/officer of the company. It is the employer's responsibility to notify employees in a timely manner when coverage has been cancelled.

Non-Renewal of Coverage

Blue Cross reserves the right to cancel group coverage for reasons including, but not limited to, the following:

- Failure to provide accurate eligibility information or other breach of contract
- Material misrepresentations
- Nonpayment of premium
- Failure to meet minimum contribution and/or participation requirements

It is the employer's responsibility to inform employees when coverage has been terminated.

Changes in Ownership

Blue Cross must be notified in writing of any changes in ownership, together with full details including, a copy of the buy-out agreement, sale of assets agreement or other agreement that resulted in the change. (These changes are subject to Underwriting review and approval.) If the new owner of the company chooses to join the plan, a new underwriting review may be required, possibly affecting premium rates. Blue Cross must also be notified if the group changes its Federal Tax ID number or the name of the company. Your group benefit agreement is not assignable or transferable and it may not, among other things, be transferred as part of a sale of the assets of the business.

Address Changes

It is recommended that an address change for your firm or employees be made in writing. Only the authorized representative of the group or the employee, respectively, can initiate an address change. Notification of *employee* address changes can be submitted via a **Change of Coverage Application**, a **Small Group Information Change Form** or in writing from the employee. Notification of an *employer* address change must be submitted on an **Employer Application** or on company letterhead and signed by an officer of the company. Please note that address changes may impact the available plan selections and current rates. It is therefore important that Blue Cross be notified of address changes in a timely fashion. These changes may also be done over the phone or online using the group administrator Web site. Please see the **Enrollment Guidelines** section; “Enrollment Actions Guide” to confirm which action can be processed over the phone.

Leave of Absence

Temporary Personal Leave of Absence

The employer determines the length of time that health benefits will remain in effect under the plan in the event of a Temporary Personal Leave of Absence. In no event shall this period exceed three months. If approved by the employer, enrolled employees are eligible to continue group coverage for themselves and their enrolled dependents for a maximum period of up to three months as set out in the group’s application. In addition, monthly premiums will continue to accrue during the Temporary Personal Leave of Absence period and the employer must continue to pay the required monthly premiums. The employer may, however, request that the employee contribute the premium during this period.

Please note that Blue Cross has no obligation and the employer has no right to continue the coverage under a temporary leave of absence for longer than the period set out in the group application. After the expiration of the leave of absence continuation of coverage, an enrollee may elect to continue coverage under COBRA or Cal-COBRA, as applicable.

It is the employer’s responsibility to notify Blue Cross of the dates that the Temporary Personal Leave of Absence begins and ends.

Temporary Medical Leave of Absence

The employer determines the length of time that health benefits will remain in effect under the plan in the event of a Temporary Medical Leave of Absence. In no event shall this period exceed six months. If approved by the employer, enrolled employees are eligible to continue group coverage for themselves and their enrolled dependents for a maximum period of six months. In addition, monthly premiums will continue to accrue during the Temporary Medical Leave of Absence period and the employer must continue to pay the required monthly premiums. The employer may, however, request that the employee pay the premium during this period. Please note that Blue Cross has no obligation and the employer has no right to continue the coverage under a temporary leave of absence for longer than the period set out in the group application. After the expiration of the leave of absence continuation of coverage, an enrollee may elect to continue the coverage under COBRA or Cal-COBRA, as applicable.

It is the employer’s responsibility to notify Blue Cross of the dates that the Temporary Medical Leave of Absence begins and ends.

Benefit Modifications

Groups are allowed to make alterations in the group benefit plan by adding new benefits, changing existing benefits or changing eligibility classifications. Benefit modifications are defined as:

- The addition of a Medical, Dental, Vision or Life plan
- Changing to a different Medical, Dental, Vision or Life plan
- Changing contribution approach
- Review of the group's Risk Adjustment Factor (RAF)
- Adding Workers' Compensation insurance
- Adding part-time employees or dependent coverage
- Changing the group's waiting period

There are specific points in time at which certain types of benefit modification requests can be made, including requests for modifications that can only be made on the group's anniversary date. Refer to the **Group Requirements and Maintenance** section; "Benefit Modifications" (for EmployeeElect plans) to determine when each type of request can be submitted.

Depending upon the type of benefit modification requested, underwriting may be required. To determine if a requested change in coverage will require underwriting, refer to the Small Group Guide to Plan Change Underwriting. Certain supporting documentation is required to review a request to modify benefits. The required documentation must be complete and accurate to process the request. The completed documentation, including all necessary Blue Cross forms, must be received by Blue Cross at least **30 days** prior to the requested effective date. The effective date of the benefit change will be assigned by the Underwriting department, if the application for the benefit modification is accepted. Please also refer to the *Benefit Modification Job Aid* to determine when each type of benefit modification may be requested and to determine what documents must accompany your request.

Guide to Plan Change Underwriting (at the employer group level)

Small Group Employee Elect Plans Only

*The Power Select HMO plan is not available in conjunction with any other HMO product(s).

MOVE TO →		Premier PPO		HMO			PPO Copay					Lumenos			Power Health Fund		High Deductible Health Plans			PPO			
		\$10 Copay	\$20 Copay	HMO 100%	Classic HMO	Saver HMO	Power Select HMO*	Advantage \$25 Copay	\$30 Copay	\$35 Copay GenRx	\$40 Copay	\$45 Copay GenRx	HSA-Compatible 1500	HSA-Compatible 3000	HIA Plus 3000	Power HealthFund 750	Power HealthFund 500	High Deductible EPO	PPO 2400 (HSA-Compatible)	PPO 3500 (HSA-Compatible)	Saver PPO	Basic PPO	
MOVE FROM:																							
Premier PPO	\$10 Copay		GI	U	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	
	\$20 Copay	U		U	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	
HMO	HMO 100%	U	U		GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	
	Classic HMO	U	U	U		GI	GI	GI	GI	GI	GI	GI	GI	GI	U	U	GI	GI	GI	GI	GI	GI	
	Saver HMO	U	U	U	U		GI	GI	GI	GI	GI	GI	GI	GI	U	U	GI	GI	GI	GI	GI	GI	
	Power Select HMO*	U	U	U	U	U		U	U	GI	U	GI	GI	GI	U	U	U	GI	GI	GI	GI	GI	
	Advantage \$25 Copay	U	U	U	U	U	GI		GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	
PPO Copay	\$30 Copay	U	U	U	U	U	GI	U		GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	
	\$35 Copay GenRx	U	U	U	U	U	U	U	U		U	GI	GI	GI	U	U	U	GI	GI	GI	GI	GI	
	\$40 Copay	U	U	U	U	U	GI	U	U	GI		GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	GI	
	\$45 Copay GenRx	U	U	U	U	U	U	U	U	U	U		GI	GI	U	U	U	GI	GI	GI	GI	GI	
	HSA-Compatible 1500	U	U	U	U	U	U	U	U	GI	U	GI		GI	U	U	U	GI	GI	GI	GI	GI	
Lumenos	HSA-Compatible 3000	U	U	U	U	U	U	U	U	U	U	U		U	U	U	GI	GI	GI	GI	GI	GI	
	HIA Plus 3000	U	U	U	U	U	GI	U	GI	GI	GI	GI	GI	GI	U	U	GI	GI	GI	GI	GI	GI	
	Power HealthFund 750	U	U	U	GI	GI	GI	U	U	GI	GI	GI	GI	GI	GI		GI	GI	GI	GI	GI	GI	
Power Health Fund	Power HealthFund 500	U	U	U	GI	GI	GI	U	U	GI	GI	GI	GI	GI	GI	U		GI	GI	GI	GI	GI	
	High Deductible EPO	U	U	U	U	U	GI	U	U	GI	GI	GI	U	U	U	GI	U		GI	GI	GI	GI	
	PPO 2400 (HSA-Compatible)	U	U	U	U	U	U	U	U	U	U	U	U	GI	U	U	U	GI		GI	GI	GI	
High Deductible Health Plans	PPO 3500 (HSA-Compatible)	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	GI	U		GI	GI	GI	
	Saver PPO	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U		GI	
	Basic PPO	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U		

How to use the Employer Plan Change Guide

1. Identify your current plan in the left vertical column.
2. Identify the plan you are interested in moving to along the top row. This plan would **replace** your current plan.
3. Follow each line to their meeting point. If the box indicates:

U = Underwriting approval is required (underwriting is usually required when a request is made to move to a plan with greater coverage).

GI = No underwriting approval is required (usually, underwriting approval is not required when a request is made to move to a plan with lesser coverage).

Note: When you move to a less expensive plan, you may also be moving to a plan with less coverage. For groups currently with only a single plan or designated plan options, underwriting approval is required if additional plans are added.

Changes in Coverage

Coverage changes may be requested at specific times, by submitting required documents. All necessary forms and documentation must be complete and accurate, and received by Blue Cross at least **30 days** prior to the requested effective date. Depending on the change requested, underwriting approval may be required. The effective date of the requested change will be assigned by the Underwriting Department if the request is approved.

Requested Change	When Eligible	Required Documents
Change in Employer Contribution Level	On anniversary date or six months after original effective date (once in a 12-month period)	Letter on company letterhead, signed by an owner/officer (subject to Underwriting Approval)
Add Part-Time Employee Eligibility or change part-time coverage from one option to the other (15-29 hours or 20-29 hours per week)	On anniversary date	<ol style="list-style-type: none"> 1. Employer Application 2. Letter from Group 3. DE-6 (reconciled by listing employees' status; i.e., full time, part time, etc.) 4. Employee Applications for all eligible part-time employees
Integrate Workers' Compensation coverage	Anytime	<ol style="list-style-type: none"> 1. Letter from Group 2. Contact Employers Compensation Insurance Company at (800) 520-1683
Add available Dental coverage	First of the month following receipt of all documentation	<ol style="list-style-type: none"> 1. Employer Application 2. Letter from Group 3. DE-6 (reconciled by listing employees' status; i.e., full time, part time, etc.) 4. Employee Applications for all enrolling employees
Add Life Insurance or Increase existing coverage	First of the month following receipt of all documentation	<ol style="list-style-type: none"> 1. Employer Application 2. Letter from Group 3. DE-6 (reconciled by listing employees' status; i.e., full time, part time, etc.) 4. Employee Applications for all enrolling employees (Subject to Underwriting Approval)
Risk Adjustment Factor (RAF) change	On anniversary date	<ol style="list-style-type: none"> 1. Employer Application 2. Letter from Group 3. DE-6 (reconciled by listing employees' status; i.e., full time, part time, etc.) 4. Employee Applications for all enrolling employees (Subject to Underwriting Approval)

Letters from the group must be on company letterhead, and signed by an officer or owner.

Continuation of Coverage

When members' employment with the group has been terminated, they **must be cancelled** from the group as an active employee. If the past employee is eligible for COBRA or Cal-COBRA and later selects this option within guidelines described by law, Blue Cross will re-enroll the member with COBRA or Cal-COBRA coverage.

The employer is obligated under law and by contract to Blue Cross to notify employees of termination of coverage and of any rights to continue coverage. Failure to do so exposes the employer to liability to the employee and to Blue Cross.

Cal-COBRA

Under California law AB1401, Cal-COBRA provides continuation of coverage for groups of two to 19 eligible employees for at least 50% of the working days in the previous calendar year. Groups of one employee are not eligible for Cal-COBRA.

An employee and/or his/her eligible dependents are eligible for continuation of coverage under Cal-COBRA for up to 36 months (if they were enrolled in Cal-COBRA on or after 01/01/03), if coverage was terminated due to any of the qualifying events listed below:

- Death of the plan subscriber (continuation for dependents)
- Employee's termination of employment, or reduction in hours
- Spouse's divorce or legal separation from the subscriber, or legal termination of registered domestic partnership
- Loss of eligible dependent status of an enrolled child
- Subscriber becoming entitled to Medicare
- Loss of eligible status of enrolled family member

Notification of a qualifying event to Blue Cross is the subscriber's responsibility, **except** that the employer must notify Blue Cross in the event of termination of employment or a reduction in hours, within 30 days from the date the event occurred. Blue Cross must be notified of the occurrence of any other qualifying event by the subscriber within 60 days of the event. Use section 1 of the Small Group Information Change Form to notify Blue Cross of the date and nature of the qualifying event. A description of the qualifying event must be included in section 1 of the Small Group Information Change Form. Notification of qualifying events must be submitted to Blue Cross in writing.

Within 14 days of notification to Blue Cross of a qualifying event, the subscriber will receive notice from Blue Cross regarding enrollment and premium for the continuation of coverage. Continuation of coverage offers the same medical and dental coverage in effect at the time of the subscriber's qualifying event. The subscriber's coverage is subject to the same changes in benefits and premiums that affect the group plan.

The premium is billed on a monthly basis directly to the subscriber. It is the responsibility of the subscriber to pay the premium each month. Premiums begin to accrue from the date of cancellation of coverage for the employee under the group policy. No lapse in coverage may occur, therefore premiums from the date of cancellation are due through the date of Cal-COBRA election. Failure to pay within the specified deadline will result in termination of coverage with no option to reinstate. As a courtesy to the group, Cal-COBRA members are listed on the Small Group bill. The employer will not be charged the Cal-COBRA premiums.

MORE ABOUT GROUP REQUIREMENTS AND MAINTENANCE ...

COBRA

Participation in the employee's benefit plan, as well as coverage under whatever medical programs are provided by the employer to employees and their dependents, may be continued under a federal law known as COBRA for groups that employ 20 or more employees for at least 50% of the previous calendar year. Administration, for the purpose of compliance with COBRA, is the obligation of the employer under this federal law. Blue Cross is not responsible for COBRA administration. The employer is responsible for providing satisfactory notice to employees regarding COBRA benefits, as well as disclosure and other administrative obligations imposed under ERISA.

Eligible former employees have a 60-day election period in which to decide if they will continue benefits under COBRA. Use the Small Group Information Change Form to notify Blue Cross that an employee has elected to continue coverage under COBRA. Complete section 1 to report termination of the employee and notify Blue Cross that the employee has opted to continue benefits under COBRA. This section must be completed in order to begin COBRA coverage in the event of termination of employment. If COBRA is elected within the required 60-day decision period, Blue Cross will reinstate employee and/or dependent coverage retroactive to the original employment or coverage termination date, without a lapse in coverage.

Under California law AB1401, members covered for 18 or 29 months under COBRA are eligible to extend their coverage under Cal-COBRA for up to a combined maximum of 36 months. These new rules apply only to members who enrolled in COBRA with an effective date of January 1, 2003 or after.

Prior to a COBRA member reaching his/her end date, Blue Cross will send a notification of the option to extend coverage under Cal-COBRA for up to 36 months. This letter will also provide applicable Cal-COBRA rates. The COBRA member must respond, indicating whether he/she wishes to extend coverage under Cal-COBRA.

Medicare Part D

Effective on 1/1/06, a key element of the Medicare Part D benefit required that employers provide either a "creditable" or "non-creditable" coverage notice to their employees. This notice is for all of your Medicare beneficiaries regarding their prescription drug coverage.

The Part D benefit is an optional benefit that can be purchased by either the beneficiary or by you on their behalf. If pharmacy benefits are covered under your group insurance plan, you must inform the beneficiary whether or not the coverage is equal to the standard Medicare benefit. This is referred to as a "creditable" or "non-creditable" coverage notice.

If the beneficiary becomes eligible and decides not to sign up for Part D coverage because they have other coverage, a creditable coverage notice allows him or her to enroll at a later date without being charged a higher premium.

You are required under the Medicare Modernization Act of 2003 to notify the Centers for Medicare and Medicaid Services (CMS) of the creditable/non-creditable nature of the prescription drug coverage you provide to your Medicare-eligible members.

For samples of coverage notices, please visit the CMS (Centers for Medicare and Medicaid Services) Web site at: <http://www.cms.hhs.gov/medicarereform>, then choose the Creditable Coverage link or call Medicare at **(800) 633-4227**.

Note: Blue Cross of California and its' affiliated companies have been chosen as a provider of Medicare Part D plan options. Please have your Medicare eligible employees contact your Authorized Independent Agent or our Senior Services Department at **(866) 892-5340** for more information. You can also contact Medicare directly at **(800) MEDICARE**. TTY/TDD users call **(877) 486-2048**, 24 hours a day, 7 days a week.

HIPAA

Terminated employees and/or their dependents and who have exhausted or are not eligible for COBRA or Cal-COBRA coverage, may be able to continue coverage through the Health Insurance Portability and Accountability Act (HIPAA) or the Blue Cross Conversion plan. They may also apply for Individual Blue Cross coverage.

When advising an employee or dependent of his/her rights to continue coverage under COBRA or Cal-COBRA, the employer must be sure that the employee or dependent understands if he/she does not elect COBRA or Cal-COBRA continuation, he/she will NOT be entitled to the HIPAA guaranteed option.

Conversion

When coverage under the employer plan is terminated, employees may apply to Blue Cross within 31 days after the date of termination for a Conversion Benefit Agreement. The terms, benefits and subscription charges of the conversion plan are different from those of the employer plan. Conversion is not available if the following occur:

- Employee's coverage ends because the employer group plan terminated and is replaced within 60 days by another employer group plan
- Employee's coverage under the employer plan ends because the employee fails to pay the premium charge
- Employee is eligible for group health coverage when coverage under the employer plan ends
- Employee is eligible for Medicare coverage when coverage under the employer plan ends, whether or not the employee has actually enrolled in Medicare
- Employee is covered under an individual health plan when coverage ends

Application for Blue Cross Conversion coverage is available without a health statement if there has been no lapse in coverage. The first quarterly premium, accompanied by a completed application, must be submitted to Blue Cross.

About Claims

Filing a Claim

A properly completed claim form itemizing the services or supplies received and the applicable charges is required to claim benefits. All claims should be submitted to the address indicated on the member's ID card.

Coordination with Medicare

Your Blue Cross Small Group plan **does not** provide supplemental coverage to Medicare recipients, but does coordinate coverage with Medicare. Under TEFRA/DEFRA requirements, your Blue Cross medical policy is considered the primary payor for businesses with 20 or more employees, regardless of how many are covered under the plan. When a group has fewer than 20 employees, Blue Cross is considered the secondary payor to Medicare and does not duplicate benefits that might be available under Medicare. Blue Cross determines its benefits, subtracts them from benefits paid or payable under Medicare and pays the difference. Blue Cross is the primary payor when a group employs more than 100 employees and the Medicare recipient is disabled and under the age of 65.

Blue Cross will not provide benefits that duplicate any benefits you are entitled to receive under Medicare. This means that when Medicare is the primary health coverage, benefits are provided in accordance with the benefits of the plan, less any amount paid by Medicare. If you are entitled to Part A and B of Medicare, you will be eligible for non-duplicate Medicare coverage, with supplemental coordination of benefits. However, if you are required to pay the Social Security Administration an additional premium for any part of Medicare, then the above policy will only apply if you are enrolled in that part of Medicare.

It is the employer's responsibility to notify Blue Cross of changes in group size that also change the group's Medicare status.

All members enjoy free access to value-added services ...

Wellness Programs

Blue Cross membership has its privileges. As a member of the Blue Cross family, members have access to alternative products and services and vision savings. In addition, to help get the most from your Blue Cross coverage, we have extended our customer service to assist you in managing your health care through access to health and wellness information, high-risk pregnancy support and health management programs. Visit our Web site at www.bluecrossca.com. Click on “Healthy Living,” then click on “HealthyExtensions.”

HealthyExtensionsSM

HealthyExtensions informs members about discounts offered by independent vendors on health care products and services. Independent vendors offer access to preventive and alternative health care resources such as vitamins and nutritional supplements, weight loss, fitness clubs and equipment, massage therapy, hypnotherapy and yoga. Members can save between 10 and 50 percent on services. You can learn more online at www.bluecrossca.com. Click on “Healthy Living,” and then click on “HealthyExtensions.” Through HealthyExtensions, there are several vendors that offer vision care discounts. You and your family can receive immediate savings on all your eye care needs including eye exams, frames, lenses and contact lenses at participating locations throughout California. Using these services is as simple as showing your Blue Cross subscriber ID card. There is no paperwork to file and no waiting. To learn more about these discounts, please go to www.bluecrossca.com and click on “Healthy Living,” then click “HealthyExtensions” to view the “Hearing and Vision Services & Products” section (these discounted services are not benefits of coverage). Blue Cross does not necessarily endorse these services or products of independent vendors. These programs may be changed or withdrawn at any time without notice.

MedCall[®]

The MedCall program provides medical members with access to a registered nurse by phone 24 hours a day, seven days a week. They can answer your health questions and help you decide whether to call your physician, go to the emergency room, or treat your symptoms at home. MedCall also offers educational audiotapes on more than 230 health topics. For your health questions, MedCall at **(800) 249-3617** is here for you.

HealthyCheckSM

Blue Cross offers PPO plan members, ages seven through adult, convenient annual preventive care screenings through our HealthyCheck centers. Children ages 7-17 receive dental, vision and hearing screenings, along with required childhood immunizations, for a fee of \$25. Adult screenings, for a fee of \$25 or \$75 depending on the services received, include a health assessment, lab tests, a personalized health status report and recommendations for possible further evaluation by your physician. HealthyCheck participants can access personalized health status reports through Blue Cross’ secure, interactive Web site, enabling members to input and receive updated information and advice on general health. HealthyCheck appointments are scheduled within 60 days of request and within 30 miles of a member’s home or place of employment. Access to our interactive Web site at www.bluecrossca.com/healthycheck enables you to set up a confidential personal health record to keep track of your health status — good for life! Receive your individual health status report by mail or register your screening results directly on our designated Web site for an instant report. Either way, your health risk test is confidential. Test results are also sent to the member’s physician of choice. To schedule an appointment at a HealthyCheck center, call **(800) 274-9355**.

Health Improvement Programs

Blue Cross Health Improvement Programs provide members who have chronic conditions with tools that can help them to be more active and enjoy a fuller life. Members may choose from available programs for asthma, diabetes and congestive heart failure. Blue Cross works in partnership with members, their health care providers and employer groups to provide education, home or telephone coaching and to ensure the best care. For more information on health improvement programs, call toll-free at **(800) 522-5560**.

Healthy Living powered by WebMD

Healthy Living powered by *WebMD* provides a wealth of personalized information to assist with understanding and managing health issues, making responsible health care decisions and reaching your health care goals. For more information on Healthy Living, visit www.bluecrossca.com.

Baby ConnectionSM

Baby Connection promotes early and regular prenatal care for a healthy pregnancy and a healthy baby. Our Baby Connection nurses work with you and your doctor to create a pregnancy program around your specific needs. Nurses are available by phone, toll-free, to answer your questions concerning your pregnancy and newborn baby. To enroll in this free program available to all pregnant members, call toll-free at **(800) 769-4896** or visit our Web site at www.bluecrossca.com. Click on “Healthy Living” and then click on “Blue Cross Baby Connection.” Once enrolled, members receive an educational packet containing:

- Listen, Learn and Grow CD
- Booklets on pregnancy and baby care
- Product discounts
- Other useful information

Contents may vary as resources are updated.

BlueCard[®]

The BlueCard program allows PPO members who need care when traveling outside of California to enjoy the benefits of Blue Cross membership anywhere in the United States (subject to the terms and payment provision of their Blue Cross health plan). BlueCard offers access to doctors and hospitals outside of California in participating local Blue Cross plan networks throughout the nation, at significant savings. The program features assistance in locating participating providers from a roster including more than 70 percent of doctors and 80 percent of hospitals in America. BlueCard extends “Power of BlueSM” cost savings and the security of access to quality health care, wherever you travel within the United States.

Participating Providers can be located by calling **(800) 810-BLUE (2583)**.

Forms and Supplies

Downloading, Requesting and Ordering Forms

Blue Cross provides, at no charge, necessary forms and brochures for you to properly administer your group plan. Forms are available through several sources:

- **Go Online**
View and/or print forms from our Web site at www.bluecrossca.com. Click on “Employers” then click on “Groups with 2-50 Employees” and then click on “Forms.”
- **Call Customer Service**
Forms can be faxed or mailed to you (including large quantity orders) by calling Customer Service at **(800) 627-8797**.
- **FAX Your Order**
Completing a Supply Request Form (form SC1350) and FAX to **(800) 504-1956**.
Your order will be filled with the most recent version of the form or brochure requested.

To maintain adequate inventories, we appreciate receiving your orders 30 days in advance of the date you require the delivery. We recommend that you request supplies sufficient for a three-month period.

Please keep in mind that our forms are updated from time to time. We recommend that you check online occasionally for the most recent revisions and replace outdated stock. Submission of old, out-of-date forms may delay your requests.

Life Insurance

Offered by BC Life & Health Insurance Company (BCL&H)

This section is applicable only if you have chosen to include life insurance in your benefits package.

Premiums

Premiums for life insurance will be billed on a monthly basis and will be combined with your group's other benefit premiums in one consolidated bill (see "Billing" section). Premiums must be paid on or before the due date and should be sent with the payment coupon to the address below:

BC Life & Health Insurance Company
P.O. Box 54630
Los Angeles, CA 90054-0630

Do not adjust your bill to reflect changes in membership. Report changes on the Small Group Information Change Form (5063). The changes will be reflected with any necessary adjustments on the next month's bill.

Enrolling New Employees

An Employee Application must be submitted to enroll a new employee in life insurance (see the **Enrollment Guidelines** section; "Coverage Effective Dates" for information on when applications must be received). Applicants that apply for coverage and submit their complete, signed enrollment forms within 31 days of their eligibility date will be added as of the original effective date. However, if these forms are received after the 31 day eligibility period expires, then they are considered late enrollees, and the following applies:

- In **Contributory** groups (both employer and employees contribute to the monthly premium cost), the applicant must then satisfy Medical Evidence Underwriting; the applicant will be enrolled effective the first of the month following the approval date.
- In **Non-Contributory** groups (employer pays 100% of monthly premium cost), the applicant's enrollment will be effective on the same date as the employee's original eligibility date, and the employer will be responsible for any premium amounts due during the interim.

Changing Coverage

It is the employer's responsibility to inform Blue Cross of any change in an employee's status that would result in a change in coverage levels. For example, if your group offers more than one level of life insurance and an employee experiences a change in job classification, salary, or any other event that would cause an increase or decrease in benefits, you must inform Blue Cross immediately by submitting a new Employee Application.

Ending Coverage

It is the employer's responsibility to notify Blue Cross of a requested cancellation in coverage due to termination of employment or other reasons, including death of the employee. Notification must be given by completing a Small Group Information Change Form (5063) This should be faxed to **(805) 499-0842**. **Please do not submit the Small Group Information Change Form or any correspondence with your premium payment.**

Salary-Based Plans

If your group has elected life insurance benefits based on salary, the employer is responsible for providing updated annual base-salary information on all covered employees within 30 days of the employer's anniversary date.

Beneficiary Designations

Designation of a beneficiary is required in order to commence life insurance coverage. The name of the employee's designated beneficiary must be filed on the appropriate form (see next page) and in a manner approved by BC Life & Health. The employee may change the beneficiary at any time using the form referenced below. Any life insurance benefit payment made by BC Life & Health under the policy before receipt of such notice willfully discharges our obligation for payment.

If beneficiary designation is unclear at the time a claim is filed, a beneficiary will be assigned according to state statute.

Actions and Forms

You may view or print forms from our Web site at www.bluecrossca.com. Click on "Employers" > "Groups with 2-50 Employees" > "Forms." You may also request forms to be faxed or mailed to you by calling Customer Service at (800) 627-8797 or by faxing a Supply Request Form (SC1405) to (800) 504-1956.

Desired Action	Form to Use	Notes	Mail to:
Change employee's name or beneficiary designation	#WL4004 Life Enrollment/ Beneficiary Designation	Change will not become effective until form is received by BCL&H	BC Life & Health Insurance Small Group Services P.O. Box 9062 Oxnard, CA 93031-9062
Request Life Insurance conversion	#10455 Request for Life Insurance Conversion	Completed form and premium payment must be received by BCL&H within 31 days of the date an employee becomes ineligible for group Life/AD&D insurance due to termination of employment, retirement or any other reason. <i>It is the employer's responsibility to notify employees of their right to convert Life benefits.</i>	BC Life & Health Insurance Specialty Finance Dept. AC12A 21555 Oxnard Street Woodland Hills, CA 91367
Claim death benefits	#3366 Beneficiary Claim & Group Policy- holder Statement	Employer is responsible for submitting a Life claim upon the death of an insured employee.	BC Life & Health Insurance Company Life Claims Service Center P.O. Box 724767 Atlanta, GA 31139-1767
Assign sole right of ownership	#WL4005 Absolute Assignment	Employee must complete and submit Absolute Assignment to assign the sole right of ownership to a named assignee(s), including privileges and rights to beneficiary designation.	
Claim benefits prior to anticipated death	#3365	Employee completes 3365: Claim for Personal Accelerated Death Benefits	
	#3364	Attending physician completes 3364: Accelerated Death Benefits Physician Statement	
Claim benefits for dismemberment or loss of an eye	#WL2006	Employee completes WL2006, Affidavit of Claimant Form	
	#WL2008	Employer completes WL2008, Certificate of Employer or Superior Officer	
	#WL2007 or WL2009	Employee's doctor completes WL2007 if dismemberment, or WL2009 if eye loss	
Claim total disability benefits	#WL2004 Total Disability Claim Form – Waiver of Premium	<i>It is the employer's responsibility to notify disabled employees of their right to waiver of premium benefits.</i> See Important Disability Notes below for critical information.	

Waiver of Premium

- If an employee becomes completely disabled prior to age 60 and remains totally and continuously disabled, BCL&H will pay the insured employee's beneficiary the applicable life insurance amount according to the Schedule of Benefits upon the death of the insured.
- In no event, however, will the claim amount exceed the amount of the insurance in force at the time the total disability began.
- To initiate this benefit, Blue Cross must be notified within 12 months from the date of the disability.
- If the disability has been continuous for at least nine months (and no more than 12 months has passed from the date of total disability), a Total Disability Claim Form (WL2004) must be completed.
 - The Policyholder section of the form must be completed by the employer and the Insured section must be completed by the employee.
 - The form must be received by BCL&H within 12 months of the last day worked due to the disability.
- If a death occurs during the period of total disability, whether or not the initial notification of disability has been made, a claim may be submitted.

Workers' Compensation

Offered by Employers Compensation Insurance Company (ECIC)

Blue Cross and Employers Compensation Insurance Company (ECIC) have teamed together to offer employers a convenient, cost-saving option to integrate Medical and Workers' Compensation coverage.

- **Save 10% automatically** on the Workers' Compensation portion of the integrated monthly billing.
- **Potential additional savings** on the Medical portion if your group qualifies (underwriting is required).

For more information, talk with your Blue Cross agent or call **(800) 520-1683**.

How to Submit Payment

Payments should be submitted to Blue Cross of California at the following address:

**Blue Cross of California
P.O. Box 54630
Los Angeles, CA 90054-0630**

Blue Cross will bill you 30 days in advance of your premium due date. Remove the coupon from the bottom of the bill and return it with your payment. Keep the top section for your records and return the coupon with your remittance. It is important that you pay the exact amount of the premiums shown on your bill.

For groups with Workers' Compensation coverage, separate spaces are provided on the coupon for the Blue Cross premium payment and the Workers' Compensation payment. Please indicate on the coupon how much of your payment is for Blue Cross and how much is for Workers' Compensation so that we can correctly apply your payment.

Please note that ECIC Workers Compensation policies and Blue Cross of California / BC Life and Health Medical/Dental/Vision or Life Policies may have different grace periods. Please refer to your policies grace period to avoid a service interruption.

How to Cancel

Please submit cancellation requests in writing by fax to **(805) 499-7214** or by mail to:

**Employers Compensation Insurance Company
P.O. Box 9057
Oxnard, CA 93031**

Integrated MediComp Savings

All Employers Compensation Insurance Company Workers' Compensation accounts written through the Newbury Park office are eligible to be integrated and are eligible for any premium savings available. Any applicable medical savings is subject to underwriting approval.

Workers' Compensation is provided under policies issued by Employers Compensation Insurance Company.

Claims Kit

In a separate mailing from your policy, you will receive a claims kit containing the forms necessary for your compliance with state requirements in employer handling and reporting of Workers' Compensation claims and injuries. These forms include:

- Posting Notice (English and Spanish)
- Facts about Workers' Compensation (English and Spanish)
- Facts for Injured Workers (English and Spanish)
- Employee Claim Form (DWC-1)
- Employee Accident Investigation Report
- Supervisor Accident Investigation Report

To report a claim, please contact Employers Compensation Insurance Company's 24-hour toll-free Claims Reporting Service at **800-232-3085**.

Medical Treatment and Network Kit

At the time you receive your claims kit, you will also receive the necessary resource materials to direct and channel injured employees to appropriate medical network facilities having Blue Cross of California arrangements through CaliforniaCare, Prudent Buyer and their Workers' Compensation subsets available to you.

Claims kits are only sent with the initial policy. If a new claims kit or additional kits are needed, contact Employers Compensation Insurance Company underwriting at **(800) 520-1683**.

Mandated Forms

Posting Notice

You must display a Posting Notice at each of your locations where it may be seen by all employees. The expiration date of your policy must be completed on the notice(s). Also include the emergency numbers for Fire, Police, Doctor and Hospital.

Facts about Workers' Compensation

This pamphlet, designed for your employees, explains the Workers' Compensation benefit, including who's covered, what's covered, how to report an injury and whom to contact for additional information. In addition to placing this pamphlet beside the Posting Notice, the law requires that it be provided to every new employee either at the time of hiring or by the end of the first pay period.

Información Acerca de la Compensación de Trabajadores

This is the Spanish version of the pamphlet "Facts about Workers' Compensation."

Facts for Injured Workers

The pamphlet provides an overview of Workers' Compensation benefits, including what to do if there is a problem and where to go for additional information.

Información Para Trabajadores Lesionados

This is the Spanish version of the pamphlet, "Facts for Injured Workers."

Employee's Claim for Workers' Compensation Benefits (DWC-1)

California law requires the following:

Step 1: Provide form to employee, personally or by First Class mail, within one working day of receiving notice or knowledge of the employee's injury which resulted in lost time beyond the date of the injury or which resulted in medical treatment other than first aid. We recommend you make an entry in the Employee Injury Log at this time, even if treatment is refused.

Step 2: When the employee returns the claim form to the employer, the employee keeps the "Employee's Temporary Receipt."

Step 3: When the claim form is returned, the employer must date-stamp all copies and return all but one dated copy to the injured worker.

Step 4: Employer promptly forwards the "Insurer copy" to Employers Compensation Insurance Company (ECIC). The California Labor Code calls for various penalties or fines including, failure to notice a delay or make payment of benefits within 14 days of the date of knowledge of disability.

Prompt reporting is essential to prompt disability payment. We strongly recommend that you contact ECIC's 24-hour Claims Reporting Service at **(800) 232-3085** to report all injuries. If the claim is reported by telephone to this number, it is not necessary to complete the Employer's First Report of Injury (Form 5020) unless you wish to do so. ECIC will give written confirmation of receipt of your telephone report, as well as a completed 5020 form by your choice of fax or mail.

P.O.P., FSA & COBRA Administration

Offered by Ceridian Benefits Services

Section 125, Premium Only Plan (P.O.P.)

If your group would like to apply for a Section 125 Premium Only Plan, which allows employees to contribute their share of premiums on a pre-tax basis, as well as providing certain tax advantages to the employer, you must submit a completed P.O.P. application form along with a separate enrollment check (if applicable). The form is part of the Blue Cross of California Employer's Guide to P.O.P., which may be ordered on the Small Group Supply Request Form, or requested from your Blue Cross agent or Membership Services.

FSA and COBRA Administration

Flexible Spending Accounts (FSA) Administration Services

Ceridian Benefits Services offers Flexible Spending Accounts (FSA) to help maximize pre-tax dollars and reduce employer payroll taxes. An FSA allows Small Group members to reserve a specific amount from their paychecks on a pre-tax basis each year, in order to pay for certain health and/or dependent care expenses that are not covered through their employer insurance plans. That amount is then placed in a special account that can be used to pay for those expenses throughout the year. Expenses for daycare, prescription drugs and children who will need braces are examples of expenses that may be eligible under an FSA. Employer tax savings may even offset the entire cost of FSA administration.

When a group signs up for an FSA, a P.O.P. plan is automatically included.

COBRA Administration Services

COBRA law is complex, constantly changing and few small businesses have time to keep up. Ceridian's Cobra Continuation Service is available to assist busy small group administrators to relieve some of the confusion that comes with COBRA administration. This service is comprehensive and will minimize your involvement in COBRA, greatly reduce your compliance risk and reduce the complexity and costs associated with COBRA.

Enrollment in FSA or COBRA Services

For more information or to request an application for FSA or COBRA administration services, please contact Ceridian directly at **(877) 548-2794**. Blue Cross will not be involved in the enrollment or administration of Ceridian's FSA or COBRA services. All applications will be sent directly to Ceridian, which will be your contact for any account concerns.



BlueCross
of California



BC Life & Health
Insurance Company

The Power of BlueSM

Blue Cross of California (BCC) is a health care service plan regulated by the Department of Managed Health Care (DMHC). BC Life & Health Insurance Company (BCL&H) is an insurance company regulated by the California Department of Insurance (DOI). BCC and BCL&H are Independent Licensees of the Blue Cross Association (BCA). The Power of Blue is a service mark and the Blue Cross name and symbol are registered service marks of the BCA.

BCC offers: Power Select HMO plan and the Dental Net plan.

BCL&H offers: The three Hospital Benefits plans and the PPO \$35 Copay GenRx plan; the Dental Benefits plan; Term Life and AD&D products.

Workers' Compensation coverage is provided through Employers Compensation Insurance Company.

HealthyExtensions: These programs are provided by Blue Cross as a service to our members. These services do not constitute benefits under Blue Cross plans and are subject to change or cancellation without notice. Goods and services available through discount programs are not benefits of coverage. Blue Cross does not endorse or recommend any goods or services provided at a discount by these vendors or practitioners. These programs may be changed or withdrawn at any time without notice by the offering vendor or practitioner.

Prescription Benefits: For detailed information about your prescription drug benefits, please refer to your Prescription Drug Benefit Summary or your Evidence of Coverage (EOC) and Disclosure Form. Please call Pharmacy Customer Service at the toll-free number printed on your member ID card to obtain copies of a Prescription Drug Benefit Summary and/or Evidence of Coverage.

Blue Cross of California
Small Group Services
2000 Corporate Center Drive
Newbury Park, CA 91320

www.bluecrossca.com