

Blue Shield of California and Blue Shield of California Life & Health Insurance Company

Effective January 1, 2015

This form should be used to submit change requests for a small group renewing its coverage with Blue Shield.

Please provide all requested information to avoid any delay in processing. Subsequent billing will reflect requested changes once processed by Blue Shield.

Return to: Blue Shield of California

Complete contract changes online at blueshieldca.com

Company Information (Required) – Please provide all requested information for your group.

Group name	Blue Shield Group ID number	Group Tax ID
Renewal date	Group Administrator name	Group Administrator title

Total No. of employees _____ Total No. of eligible employees _____ Total No. of enrolled employees _____
Total No. of employees declining Blue Shield coverage _____

Note: An enrollment application or refusal of coverage is required for each eligible employee. If the group has any eligible employees who are not enrolling/enrolled and who have not provided a Refusal of Personal Coverage form to Blue Shield, please provide completed forms for these individuals with this change form.

Do you offer another carrier's HMO alongside Blue Shield? ☐ Yes ☐ No

Carrier name:

Open enrollment dates:

Contract change requests – Please complete this section to request administrative or eligibility changes to your group contract.

Employment-Based Affiliation and Waiting Periods

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

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

Employer Orientation Period – Does the group impose an orientation period for new employees? ☐ Yes ☐ No

If yes, is your orientation period 30 days or less? ☐ Yes ☐ No

Employer Waiting Period – The group may select one of the following options. Coverage for an eligible employee will become effective following completion of the waiting period on the day specified.

- ☐ Effective first of month following date of hire (Employees hired on the 1st of the month, will be effective the 1st of the following month)
☐ Effective first of month following 30 days from date of hire
☐ Effective first of the month following 60 days from date of hire
☐ Effective on the 91st day following date of hire

Medical Plan Employer Contribution Changes – Please indicate any change to the group's contribution amounts to employee coverage and/or dependent coverage below. The employer must contribute a minimum of 50% of the total employee premium for medical plan and bundled pediatric dental coverage. If 100% is paid by the employer, all eligible employees must enroll.

Current Employer Contribution Percentage (%)

_____ Employee _____ Dependent

New Employer Contribution Percentage (%)

_____ Employee _____ Dependent

Domestic partner coverage – Domestic partner eligibility is mandated per California law for any same-sex domestic partner, and opposite-sex couples where at least one partner is at least age 62 and eligible for Social Security (Narrow coverage). You have the option to extend domestic partner coverage to opposite-sex couples under age 62 (Broad coverage) at renewal by checking the box for "broad" coverage below.

Current Domestic Partner Coverage Option

☐ Narrow ☐ Broad

New Domestic Partner Coverage Option

☐ Narrow ☐ Broad

Employee Eligibility Changes – Please indicate any changes to employee eligibility requirements established by the group. For changes in eligibility based on number of hours worked, the most recent filed DE-9C must be provided with this form.

Current Employee Eligibility

- ☐ Full time (Average of 30 hours per week)
☐ Both full time and part time (Average of 20-29 hours per week)

New Employee Eligibility

- ☐ Full time (Average of 30 hours per week)
☐ Both full time and part time (Average of 20-29 hours per week)

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Change in Group Size and COBRA Status – Please complete this section if employee count has changed to impact whether the group is subject to COBRA or state Cal-COBRA requirements. Please note that Blue Shield must receive COBRA status change requests at the beginning of the calendar year. A DE-9C validating total group size is required.

- ☐ Group is currently subject to federal COBRA and will be subject to Cal-COBRA as of January 1.
☐ Group is currently subject to Cal-COBRA and will be subject to federal COBRA as of January 1.

Electronic Distribution of Evidence of Coverage (EOC) – The group is responsible for the distribution of the *Evidence of Coverage* booklets to covered employees. Electronic versions of these documents will be distributed via CD. The group is responsible for distributing the EOC using one of the following methods; 1) posting on the employer's intranet for employee access, or 2) emailing these documents directly to their employees. Printed versions of the EOC will only be mailed to the employer upon request.

- ☐ Check this box ONLY if the group elects to receive hardcopy EOC booklets. The group understands it is responsible for distributing EOCs to covered employees. ☐ Check this box to elect to receive printed, not electronic, EOC/COI booklets.

Health Plan Selection – For groups with one or more enrolling employees, the group may select either Off Exchange or On Exchange package options.

- ☐ **Blue Shield of California Off Exchange Package for Small Business** – The Blue Shield of California Off Exchange Package is the only package that may be offered alongside another carrier's HMO plan.

For groups with one or more enrolling employees offering Blue Shield of California, the group may select from one of the following four options.

- ☐ All PPO plans and Access+ HMO® plans (excludes Local Access+ HMO® plans and the Trio ACO HMO plans)
☐ All PPO plans and Local Access+ HMO plans (excludes Access+ HMO plans and the Trio ACO HMO plans)
☐ All PPO plans and the Trio ACO HMO plans (excludes Access+ HMO and Local Access+ plans)
☐ Selected plans – The group may choose up to 13 plans from the options below.

Note: You must choose one HMO network only. Access+, Local Access+, and Trio ACO HMO plans cannot be offered side by side.

PPO plans – All PPO plans may be combined with Local Access+ HMO plans or Access+ HMO plans; select up to 13 total.

PPO plans – Full PPO Network

- ☐ Platinum Full PPO 0 OffEx
☐ Platinum Full PPO 150 OffEx
☐ Gold Full PPO 0 OffEx
☐ Gold Full PPO 750 OffEx
☐ Silver Full PPO 1250 OffEx
☐ Silver Full PPO 1700 OffEx
☐ Bronze Full PPO 4500 OffEx

HSA-compatible HDHP plans – Full PPO Network

- ☐ Bronze Full PPO HSA 3500 OffEx
☐ Bronze Full PPO HSA 5500 OffEx
☐ Silver Full PPO HSA 2000 OffEx

HMO plans – you have the option of choosing from one of three different HMO plans: Access+ HMO plans, Local Access+ HMO plans, or Trio ACO HMO plans. The Access+ HMO plans, Local Access+ HMO plans, and Trio ACO HMO plans have different provider networks, and may not be combined with other HMO plan selections.

Access+ HMO Plans – Access+ HMO Network

- ☐ Platinum Access+ HMO® \$25 OffEx
☐ Gold Access+ HMO® \$30 OffEx
☐ Silver Access+ HMO® \$55 OffEx

Local Access+ HMO Plans – Local Access+ HMO Network

- ☐ Platinum Local Access+ HMO® \$25 OffEx
☐ Gold Local Access+ HMO® \$30 OffEx
☐ Silver Local Access+ HMO® \$55 OffEx

Trio ACO HMO Plans – Trio ACO HMO Network

- ☐ Platinum Trio ACO HMO \$25 OffExc
☐ Gold Trio ACO HMO \$30 OffExc
☐ Silver Trio ACO HMO \$55 OffExc

- ☐ **Blue Shield of California Mirror Package for Small Business** – These plans in these packages “mirror” the standardized plans offered through Covered California. Groups with one or more enrolling employees who select this package may select any number of plans from the options below.

Platinum Mirror Plans

- ☐ Platinum 90 HMO Network 1 Mirror
☐ Platinum 90 HMO Network 2 Mirror

Gold Mirror Plans

- ☐ Gold 80 HMO Network 1 Mirror
☐ Gold 80 HMO Network 2 Mirror

Silver Mirror Plans

- ☐ Silver 70 HMO Network 1 Mirror
☐ Silver 70 HMO Network 2 Mirror

Bronze Mirror Plans

- ☐ Bronze 60 PPO Mirror

Optional benefits – A rider for infertility benefits may be offered with either the Blue Shield of California Off Exchange Package for Small Business or the Blue Shield of California Mirror Package for Small Business. If selected, it must be offered with all medical plans.

- ☐ Infertility benefits rider

Pediatric Dental Coverage – Pursuant to state and federal law, the group must have pediatric dental coverage. Therefore, the group must choose at least one but can choose both pediatric dental plans listed below. Employees enrolling in a Blue Shield medical plan must be enrolled in pediatric dental coverage. Note: Only those ages 0 to 19 years are eligible for benefits and charged premiums.

- ☐ Children's Dental PPO for Small Business
☐ Children's Dental HMO for Small Business

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Specialty Benefit Plans – Dental, Vision, and Life Insurance plan selection – Please complete this section to indicate changes to the group's specialty benefit plans.

Section SB1 – Dental benefits

Dental Plan Options – Groups may offer Blue Shield dental coverage with a medical plan or as a standalone benefit. When adding dental coverage, please submit an enrollment, refusal of coverage, or subscriber change request form for all eligible employees and dependents who are electing dental coverage. The group may select from one of the following plan options:

☐ **Single Dental Plan Option**

☐ **Dual Choice Dental Plan Option** – Please select two plans from the options below.

☐ **Triple Choice Dental Plan Option** – Please select three plans from the options below in one of the following combinations:

☐ 2 Dental HMO plans and 1 Dental PPO plan ☐ 2 Dental HMO plans and 1 Dental INO plan ☐ 3 Dental HMO plans

Dental HMO Plans

☐ DHMO Basic ☐ DHMO Plus ☐ DHMO Deluxe ☐ DHMO Voluntary

Dental PPO Plans

<input type="checkbox"/> Ultimate Dental PPO for Small Business 50/2000	<input type="checkbox"/> Smile SM 50/1500/No Ortho/MAC
<input type="checkbox"/> Ultimate Dental Plus PPO for Small Business 50/2000	<input type="checkbox"/> Smile SM Plus 50/1500/Ortho/MAC
<input type="checkbox"/> Smile SM Deluxe 2000 50/2000/No Ortho/MAC	<input type="checkbox"/> Smile SM Value 50/1500/No Ortho/MAC
<input type="checkbox"/> Smile SM Deluxe Plus 2000 50/2000/Ortho/MAC	<input type="checkbox"/> Smile SM Plus Gold 50/1500/Ortho/U85
<input type="checkbox"/> Smile SM Deluxe 50/1500/Ortho/MAC	<input type="checkbox"/> Smile SM Basic 75/1000/No Ortho/MAC
<input type="checkbox"/> Smile SM Deluxe Gold 50/1500/Ortho/U85	<input type="checkbox"/> Smile SM Basic Voluntary 75/1000/No Ortho/MAC

Dental In-Network Only (INO) Plans*

<input type="checkbox"/> Smile SM INO Dental Plan 50/1500/Endo-Perio 80%/Ortho	<input type="checkbox"/> Smile SM INO Dental Plan 50/2500/Endo-Perio 80%/Ortho
<input type="checkbox"/> Smile SM INO Dental Plan 50/1500/Endo-Perio 80%/No Ortho	<input type="checkbox"/> Smile SM INO Dental Plan 50/2500/Endo-Perio 80%/No Ortho
<input type="checkbox"/> Smile SM INO Dental Voluntary Plan 50/1500/Endo-Perio 50%/Ortho ¹	<input type="checkbox"/> Smile SM INO Dental Voluntary Plan 50/2500/Endo-Perio 50%/Ortho ¹
<input type="checkbox"/> Smile SM INO Dental Voluntary Plan 50/1500/Endo-Perio 50%/No Ortho ¹	<input type="checkbox"/> Smile SM INO Dental Voluntary Plan 50/2500/Endo-Perio 50%/No Ortho ¹

Indicate dental plan employer contribution amount here:

For employees _____% For dependents _____%

For dental coverage, the employer must contribute at least 50% of the employee's premium (except for voluntary plans). If 100% is paid by the employer, all eligible employees must enroll.

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

¹ Voluntary vision plans require a minimum of three enrolling, eligible employees.

Section SB2 – Vision coverage

Vision Coverage* – Groups may offer Blue Shield vision coverage with a medical plan or as a standalone benefit. The group may select one plan from the following plan options:

Ultimate Vision for Small Business (12-12-12)	Preferred Vision for Small Business (12-12-24)	Enhanced Vision for Small Business (12-24-24)
<input type="checkbox"/> Ultimate Vision Plus 0/0/150/120	<input type="checkbox"/> Preferred Vision Plus 0/0/150/120	<input type="checkbox"/> Enhanced Vision Plus 0/0/150/120
<input type="checkbox"/> Ultimate Vision 0/0/150	<input type="checkbox"/> Preferred Vision 0/0/150	<input type="checkbox"/> Enhanced Vision 0/0/150
<input type="checkbox"/> Ultimate Vision Plus 15/25/150/120	<input type="checkbox"/> Preferred Vision Plus 15/25/150/120	<input type="checkbox"/> Enhanced Vision Plus 15/25/150/120
<input type="checkbox"/> Ultimate Vision 15/25/150	<input type="checkbox"/> Preferred Vision 15/25/150	<input type="checkbox"/> Enhanced Vision 15/25/150
<input type="checkbox"/> Ultimate Vision Voluntary 15/25/150 ¹	<input type="checkbox"/> Preferred Vision 0/0/120	<input type="checkbox"/> Enhanced Vision 0/0/120
<input type="checkbox"/> Ultimate Vision 0/0/120	<input type="checkbox"/> Preferred Vision 15/25/120	<input type="checkbox"/> Enhanced Vision 15/25/120
<input type="checkbox"/> Ultimate Vision 15/25/120	<input type="checkbox"/> Preferred Vision Voluntary 15/25/120 ¹	<input type="checkbox"/> Enhanced Vision Voluntary 15/25/120 ¹

Indicate vision plan employer contribution amount here:

For employees _____% For dependents _____%

For vision coverage, the employer must contribute a minimum of 25% of the total employee premium (except for voluntary plans). If 100% is paid by the employer, all eligible employees must enroll.

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Section SB3 – Life/AD&D insurance

Group Term Life Insurance* – Requires a minimum of two eligible employees.

Groups may offer Blue Shield group term life and AD&D insurance coverage with a medical plan or as a standalone benefit. The group may select one of the following three plan options and coverage amounts (if applicable).

- ☐ **Flat Amount** – All employees covered at same flat amount. \$ _____
- ☐ **Multiple of salary** – All employees covered for the same multiple of salary up to a maximum amount of 2 times annual earnings (up to maximum benefit amount). _____ times salary, maximum \$ _____
- ☐ **Graded** – Employees are covered by class (up to 4), defined with different levels of benefits.
- ☐ 1. Class description _____ flat amount \$ _____
 - ☐ 2. Class description _____ flat amount \$ _____
 - ☐ 3. Class description _____ flat amount \$ _____
 - ☐ 4. Class description _____ flat amount \$ _____
- ☐ **Dependent life insurance** – Coverage amounts listed are per dependent, and are only available for employees electing life and AD&D insurance. The maximum dependent benefit may not be more than 50% of the employee benefit. Benefits for children 14 days to 6 months are 10% of the total benefit, and there is no coverage for infants from birth to 14 days. AD&D insurance coverage is not available for dependents.

(choose one): ☐ \$1,000 ☐ \$2,000 ☐ \$3,000 ☐ \$4,000 ☐ \$5,000

Benefit amounts established by salary are rounded to the next highest \$1,000.

Indicate group term life insurance plan employer contribution amount here:

For employees _____% For dependents _____%

For life insurance coverage, the employer must contribute a minimum of 25% of the total employee premium. If 100% is paid by the employer, all eligible employees must enroll.

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

The group understands that no requested change(s) will be effective until Blue Shield has processed this request and assigned an effective date. The group or the group's broker will be notified by Blue Shield of the change, or Blue Shield can be contacted for confirmation.

Authorized group representative signature

Date

Group representative name (please print)

Group representative title (please print)