

Small Group Employers

Group Administrator Manual

May 2003



BlueCross
of California



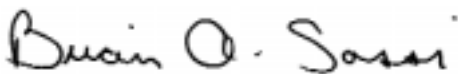
Dear Group Administrator:

Thank you for choosing Blue Cross of California and BC Life & Health Insurance Company for your health coverage. We take seriously the trust you have placed in us and look forward to serving you and your employees today and in the future.

The Group Administrator Manual is your source for information in handling day-to-day issues arising from your Blue Cross coverage. It contains information on a variety of topics including billing, enrollment guidelines, membership changes, group requirements and wellness programs. We think you will find this information helpful to you fulfilling your contractual obligations to us and your legal obligations to your employees.

We appreciate your business. As always, our goal is to provide quality products and service. If you have any questions regarding the enclosed information, please contact your Blue Cross Agent or call Customer Service at (800) 627-8797, Monday through Friday, 8:30 a.m. to midnight.

Sincerely,



Brian A. Sassi
General Manager, Small Group Services
Blue Cross of California



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SECTION 1 Important Addresses and Telephone Numbers

Questions about...	Contact	Phone Number	Address
Premiums or billing	Membership	(800) 627-8797 Fax: (805) 499-7762	Blue Cross of California P.O. Box 54630 Los Angeles, CA 90054-0630
Enrollment or Applications	Membership	(800) 627-8797 Fax: (805) 499-0842	Blue Cross of California P.O. Box 9062 Oxnard, CA 93031-9062
Spanish Customer Service	Customer Service	(800) 777-2287	Blue Cross of California P.O. Box 9062 Oxnard, CA 93031-9062
Chinese Customer Service	Customer Service	(888) 888-8368	Blue Cross of California P.O. Box 9062 Oxnard, CA 93031-9062
Cal-COBRA, COBRA, HIPAA and/or Medicare	Membership	(800) 627-8797 Fax: (805) 480-8328	Blue Cross of California P.O. Box 9062 Oxnard, CA 93031-9062
Medical Claims	Claims	(800) 627-8797	Blue Cross of California P.O. Box 60007 Los Angeles, CA 90060-0007
Dental Claims	Dental Services	(888) 209-7852	Dental Services P.O. Box 9066 Woodland Hills, CA 93031-9066
Pharmacy (Retail)	Blue Cross of California	(800) 700-2533	Blue Cross of California % Prescription Drug Program (Retail Pharmacy) P.O. Box 4165 Woodland Hills, CA 91365-4165
Pharmacy (Mail Order)	Precision Rx	(866) 274-6825 Hearing impaired: (800) 238-0756	Precision Rx (Mail Order) P.O. Box 961025 Fort Worth, TX 76161-9863 www.PrecisionRxonline.com

Questions about...	Contact	Phone Number	Address
Life Claims	Life Claims	(888) 231-5032	BC Life & Health Insurance Company Group Life Department P.O. Box 1210 Springfield, MA 01101-1210
Coverage while traveling	BlueCard	(800) 810-2583	N/A
Forms and Supplies	Arvato (formerly known as Bertelsmann)	(661) 257-0584	24730 W. Avenue Rockefeller Valencia, CA 91355
Section 125 Premium Only Plan	Ceridian Benefits Services	(800) 767-4969	N/A

Workers' Compensation (Fremont Employers and Affiliated Companies)

Questions about...	Contact	Phone Number	Address
Underwriting & Claims	Fremont	Underwriting: (800) 520-1683 Claims: (805) 480-8905	Fremont Workers' Compensation Underwriting P.O. Box 9057 Oxnard, CA 93031-9057
Premiums	Fremont	(800) 662-2733	Fremont Workers' Compensation Premiums P.O. Box 9096 Oxnard, CA 93031-9096

SECTION 2 Self-Service Options

Internet

Blue Cross is committed to providing members and group administrators with easy access to information important to them. A comprehensive source of information can be found on our Web site at www.bluecrossca.com.

For Group Administrators:

This portion of the site provides access to forms and group administration information, including:

- Printable Employee Applications, Change of Coverage Applications and Small Group Employee Information Change Forms
- Review Frequently Asked Questions
- View and print the Group Administrator's Manual
- Find important telephone numbers and addresses

To access the Small Group Administrator section of the Web site, go to www.bluecrossca.com. Click on "Employers" and then click on "Groups with 2-50 Employees."

Save time. Experience online convenience and watch for future Web site enhancements.

For Members:

Information available through the Member portion of the site is in a secure format, with confidential information accessible only through the use of a personal identification number (PIN). A PIN can be requested at the Web site and will be mailed to you at the address in our records. When using the site, all personal information is encrypted to ensure privacy. Personalized information viewable at the site includes:

- Contract information
- Address information
- Member medical plan coverage
- Claim status
- Available providers, including specialists and their location

To access the Small Group Member section of the Web site, go to www.bluecrossca.com. Click on "Members" and then click on "Groups of 2-50".

Interactive Voice Response System

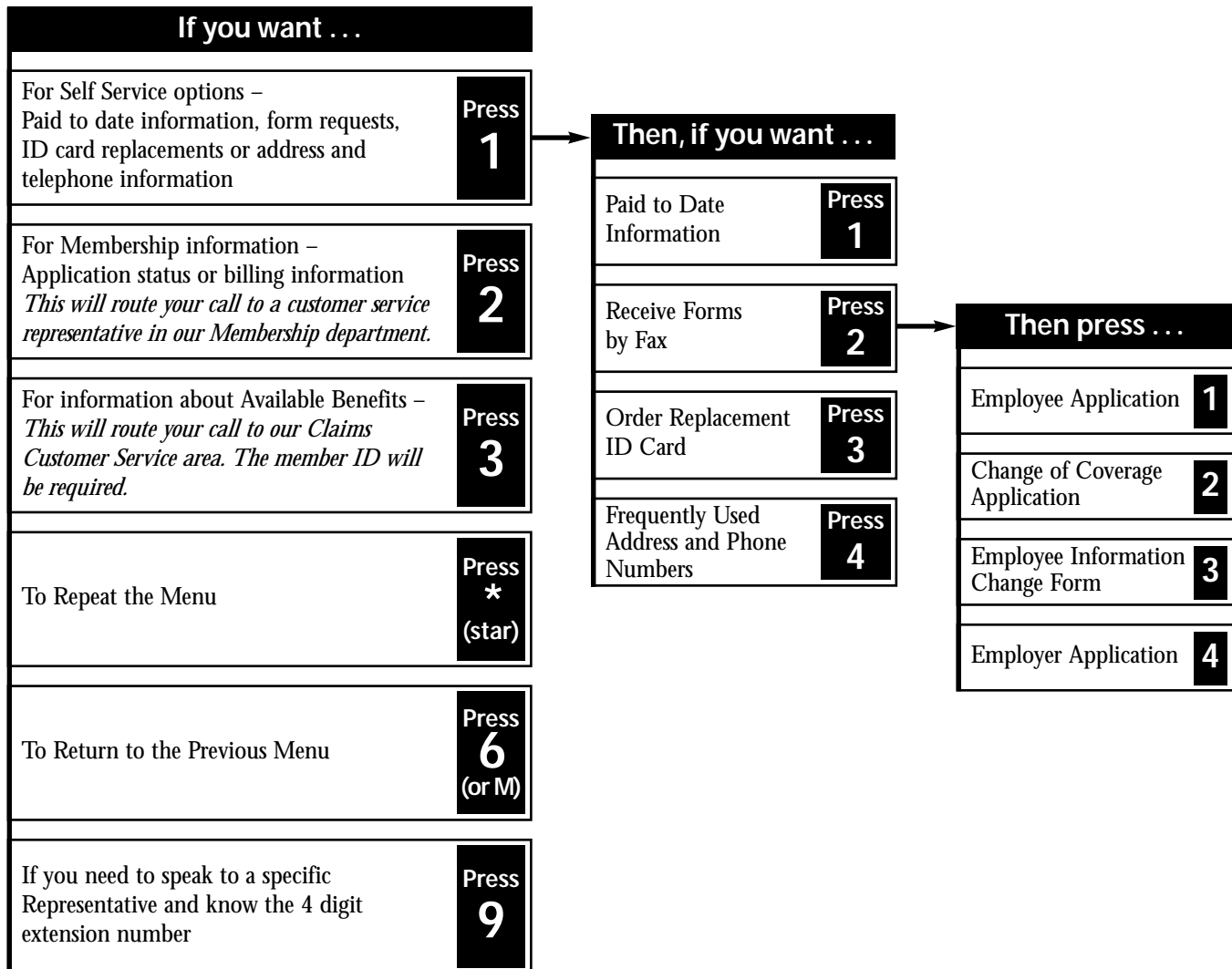
Blue Cross' Interactive Voice Response System (IVR) guides callers to a customer service representative or self-service automated information via a series of instructions and prompts.

(800) 627-8797

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 <i>You will be asked to enter your group number</i>	Press 4
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4 Group Administrator Options



SECTION 3 Billing

Premium Rates

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

Various provisions of the law preserve and govern the frequency at which benefit 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. Since rates are generally driven by the cost of health care and the economy, it is not possible to predict when or if changes will be made to your rates. However, we feel it is useful and important for you to 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 or at the individual group member level, where only a specific employee experiences a rate change. At the group level, there are two components of your rate: Standard Employee Risk Rates (SERR) and Risk Adjustment Factor (RAF). 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.

Standard Employee Risk Rate (SERR)

The SERR is the base premium for each Blue Cross medical product. The SERR rate is guaranteed for a minimum of six months. This rate guarantee period may be extended, upon new group installation only, depending on group size. We are required to notify you 30 days in advance of any change in your SERR.

Risk Adjustment Factor (RAF)

We may re-evaluate your group, but will not change the RAF more often than once every 12 months. The 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 are required to notify you 30 days in advance of any change in your group's RAF.

Billing Cycle

You will receive a Small Group bill from Blue Cross of California on a monthly basis. The bill will include the due date, total premium due, past due amounts and any applicable fees. Detach the coupon from the billing statement and include the premium payment in the envelope provided. If your group plan includes more than one product with Blue Cross of California, you will receive one consolidated bill for all products.

It is the group's responsibility to check each monthly statement for accuracy and to notify Blue Cross immediately if there are discrepancies. It is important that you pay the amount of the premium listed on your bill. Credit for retroactive deletions prior to the month for which you are being billed will not be processed. Please submit a single check for your bill. It is not necessary to submit a separate check for each product.

If your premium becomes delinquent, your next bill will include any past due amount necessary to bring your account current.

Important Note: Payment must be received on or before the due date shown on the bill or the premium will be considered delinquent and your group policy will be subject to cancellation.

Premium Payments

Adjustments to Your Bill

Remittance of a premium payment other than the amount indicated on your bill may result in a premium shortage or overage. 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 of California. Please do not submit new applications with a bill. 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 payment(s) should be made as billed. It is recommended that terminations be submitted to Blue Cross as they occur for timely processing. Credit for terminations will be reflected on your next scheduled billing statement after the deletion(s) has been processed by Blue Cross of California.

Important Note: Please **do not** submit your termination(s) with your premium payment. Refer to the address and/or fax number on the Small Group Employee Information Change Form or the address referenced at the beginning of this manual.

Preparing to Send Your Payment

What to Include:	When to Include it:
Write your group number on the face of your 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. 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.**

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.

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 of California.

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.

Late Payment Fee

A late charge of \$25.00 is 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.

SECTION 4 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 Tax Identification Number via a W-2 form are considered to be eligible for enrollment.

Part-Time

A part-time employee must be actively engaged in the conduct of the business of the employer, with a normal schedule of at least 20 but not more than 29 hours per week. 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 "Benefit Modifications" subsection). 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. 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 and reside 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 High Deductible EPO plan and all HMO plans are only available to employees who reside in California.** 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 prior to the requested effective date. 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 "Late Enrollees" subsection).

The Small Group employer is responsible for ensuring that sections 2 and 4 of the Employee Application are completed for any employees and/or eligible dependents declining coverage. This is in accordance with California State Law AB1672 and is referenced in the Group Benefit Agreement.

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.

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 application is signed by the employee
- 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 becomes the first of the month following approval of the application
- 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 will be returned for completion. **The date upon which the fully completed application is once again received by Blue Cross is used in determining the effective date.** Fully completed applications must be received prior to the effective date requested and within the eligibility period.

Examples of effective date for eligible employees:

	Example 1	Example 2	Example 3	Example 4
Hire Date	6/1	6/5	6/11	6/30
2-Month Employer Waiting Period Expires	8/1	8/5	8/11	8/30
Eligibility Date	8/1	8/5	8/11	8/30
Complete Application Received	7/2	8/5	10/3 Late Enrollment	9/6
Effective Date	8/1	9/1	Potentially the 1st day of the month following 12-month waiting period	10/1

Examples of effective dates for eligible employees who decline coverage:

	Example 5		Example 6
Hire Date	6/15	Hire Date	6/15
2-Month Employer Waiting Period Expires	8/15	2-Month Employer Waiting Period Expires	8/15
Eligibility Date	9/1	Eligibility Date (Enrolls Eligible Employee Only, declining 1 or more dependents)	9/1
Declination of Coverage Received	9/6	Employer Anniversary	2/1
Employer Anniversary	2/1	Complete Application to Enroll Dependents Received	1/20
Complete Application Received	1/20	Effective Date	2/1
Effective Date	2/1		

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.

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, with the exception of Domestic Partners, a separate eligibility expansion (see “Domestic Partners” section for more information). The following persons, if not otherwise covered as subscribers in your Blue Cross plan or in military service, are considered eligible dependents:

- The lawful spouse of the opposite sex
- A certified domestic partner (if domestic partner eligibility has been elected by the employer)
- Any unmarried, biological or legally adopted child (see “Children” subsection for age requirements)
- A stepchild of the subscriber or enrolled spouse
- A child (ward) of a subscriber or the subscriber’s enrolled spouse who is named the **permanent** legal guardian
- A dependent child of a domestic partner, only if he/she is the employee’s biological or adopted child and only if domestic partner eligibility has been elected by the employer

New Spouse

Application for coverage for a new spouse must be submitted to Blue Cross within 30 days of the legally valid marriage between two persons of the opposite sex. Coverage for the new spouse will begin on the first day of the month following receipt of the completed and approved Employee Application.

Children

The subscriber's or spouse's unmarried biological child, stepchild, ward or legally adopted child are eligible for coverage, if they meet any of the following criteria:

- Unmarried children of the subscriber or the subscriber's enrolled spouse, up to their 19th birthday.
- Unmarried children of the subscriber or subscriber's enrolled spouse, 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 (wards) of a subscriber or the subscriber's enrolled spouse who is named the **permanent** legal guardian by a final court decree or order. The ward will be considered an eligible dependent child, subject to all rules and age limitations that apply to an eligible dependent child. To apply for coverage, the permanent legal guardian must submit a new Small Group Employee Application or a 2-50 Existing Small Group Employee Addition Application, along with a "Letters of Guardianship" form from the court, showing the filing date and court seal. For newly acquired wards, an application must be filed within 30 days of issuance of the final court decree or order of legal guardianship and must be added within 30 days of acquisition or they will be treated as Late Enrollees.
- 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 mental retardation 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.

Newborns

Newborn children are automatically covered for illness or injury for the first 30 days following birth. Employee requests for enrollment of newborn children may be made by telephone *within* the first 30 days following birth by contacting the Membership department. Blue Cross requires that an Employee Application be completed for enrollment requests made *after* the first 30 days of life. Without this request, coverage terminates at the end of the 30-day period. Newborns are never automatically enrolled for coverage beyond this 30-day period. The employee must initiate the addition of their new dependent based on the above recommendations. Payment of claims does not secure continued coverage.

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

Adoptions

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 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. Such documentation must accompany the Small Group Change of Coverage Application.

Application for coverage for children must be submitted within 30 days of obtaining the right to control the health care needs of the child.

Domestic Partners

Coverage for Domestic Partners is an expansion of group eligibility and is not automatically included in your group policy. The addition of Domestic Partner eligibility to the group plan is at the sole discretion of the employer and is only available if the employer selects this option. Domestic Partner eligibility may be added to your group policy only on your group's anniversary date.

A new Master Application is required and it must be received during the month prior to the anniversary date. Domestic Partner eligibility will not be added on a retroactive basis. If Domestic Partner coverage is elected, it must be offered to all eligible employees within the group.

In order for an employee's Domestic Partner to be enrolled in the plan, the employee must submit both:

- An Employee Application requesting or declining enrollment
- A copy of the Certificate of Domestic Partnership, registered with a California city or county OR a signed and notarized Affidavit of Domestic Partnership OR a valid Declaration of Domestic Partnership filed and stamped by the Secretary of State, if applicable

Where an eligible employee requests self-coverage but chooses to decline coverage for a Domestic Partner, the employee must complete the declination (section 4) on the Employee Application.

If a Domestic Partnership terminates, the employee must notify the group administrator and provide a signed and 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 the next SERR rate change or six months after the previous Domestic Partner was removed from the plan.

Children of Domestic Partners

Section 152 of the Internal Revenue Code provides the definition for children of a Domestic Partner. However, Blue Cross has elected not to cover dependent children of Domestic Partners. The dependent children of Domestic Partners can only be enrolled as dependents under the natural or adoptive parent's policy. Please refer to the previous page defining eligible children.

Enrolling Dependents

Dependents must request coverage within the required time frame or they may be considered Late Enrollees. To enroll the dependents of employees already enrolled in the plan, submit an Employee Application or a 2-50 Existing Small Group Employee Addition Application along with any additional required documentation. You may forward the Employee Application to Blue Cross with your premium payment. Blue Cross will determine the effective date of dependent coverage based on the date the dependent became eligible to enroll (see "Application Requirements" chart), the date the fully completed application is received by Blue Cross and when Blue Cross approves the application. Dependents who decline coverage upon initial enrollment may be eligible to enroll for coverage on the group's anniversary date.

Effective dates are determined as follows:

- a) If the fully completed application is received by Blue Cross after the eligibility date, but within 30 days of becoming eligible, the effective date becomes the first of the month following approval of the application.
- b) 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 day may be delayed up to one year from the date of application for enrollment.

Enrolling Dependents – Application Requirements

Type of Dependent	Application for coverage or declining coverage must be received:	And must include (if requesting coverage):
New Spouse	<ul style="list-style-type: none"> • Within 30 days of marriage 	<ul style="list-style-type: none"> • Employee Application or 2-50 Existing Small Group Employee Addition Application
Newborn Child	<ul style="list-style-type: none"> • Within 30 days of birth • After 30 days 	<ul style="list-style-type: none"> • Verbal or written notice • Employee Application or 2-50 Existing Small Group Employee Addition Application
Adopted Child	<ul style="list-style-type: none"> • Within 30 days of adoption or the right to control healthcare 	<ul style="list-style-type: none"> • Employee Application or 2-50 Existing Small Group Employee Addition Application
Stepchild	<ul style="list-style-type: none"> • Within 30 days of marriage 	<ul style="list-style-type: none"> • Employee Application or 2-50 Existing Small Group Employee Addition Application
Ward of a Permanent Legal Guardian	<ul style="list-style-type: none"> • Filed within 30 days of issuance of the final court decree or order of legal guardianship • Added within 30 days of acquisition 	<ul style="list-style-type: none"> • Employee Application or 2-50 Existing Small Group Employee Addition Application • “Letters of Guardianship” form from the court, showing the filing date and court seal
Domestic Partner	<ul style="list-style-type: none"> • At the time the group adds Domestic Partners as part of a benefit modification • Prior to conditions which would otherwise cause the Domestic Partner to be a Late Enrollee 	<ul style="list-style-type: none"> • Employee Application or 2-50 Existing Small Group Employee Addition Application • Certificate of Domestic Partnership, OR a signed and notarized Affidavit of Domestic Partnership OR a valid Declaration of Domestic Partnership, filed and stamped by the Secretary of State of California.
Dependent who previously declined coverage	<ul style="list-style-type: none"> • During the group's open enrollment period • Prior to conditions which would otherwise cause a dependent to be a Late Enrollee 	<ul style="list-style-type: none"> • Employee Application or 2-50 Existing Small Group Employee Addition Application • Proof of qualifying event for a Late Enrollee

Applications with missing information are considered to be incomplete and will be returned for completion. The date upon which the fully completed application is once again received by Blue Cross 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 will be 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 a 2-50 Small Group Employee Application or the new 2-50 Existing Small Group Employee Addition Application (which may only be used by existing groups because it does not contain pertinent medical history information and is shorter than the Small Group Employee Application). The application must be received by or before the first day 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

Employee Application Tips

- Use black or blue ink and print clearly
- Include the Small Group number at the top of the application
- Make sure all required areas of the form are completed
- If an HMO plan is selected, a PMG or IPA and office number is required
- If Dental Net or Blue Cross Dental SelectHMO is selected, a dental office and office number must be selected
- **All** boxes in Section 2 must be completed
- Social Security number(s) are required
- If benefits are requested, all questions in either Section 5 or Section 5A must be answered (it may be necessary for the Group Administrator to instruct the employee on which section of the application to complete, based on the number of employees enrolled in the group)
- The employee must either enroll or decline coverage for dependents listed on the application
- 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 must also sign and date the application if applying for coverage
- If Life insurance is requested, a beneficiary **must** be named
- If the employee is electing coverage for his/her Domestic Partner, the Domestic Partner must also sign the application and attach the Affidavit of Domestic Partnership

Enrollment Forms Guide

ACTION	Employee Application or 2-50 Existing Small Group Employee Addition Application	Change of Coverage Application	Small Group Employee Information Change Form	Employer Application	COMMENTS
Add a new employee and/or dependents to the plan	X				Additional documentation may be required depending on type of dependent
Add dependents for an existing employee	X				Additional documentation may be required depending on type of dependent
Decline coverage for an employee and/or dependents	X				Section 2 and 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		Submit immediately upon termination to Membership Services
Discontinue coverage for employees and/or dependents who still remain eligible under the plan	X		X		Section 2 and 4 of the Employee Application must be completed (failure to provide this may delay coverage if selected at a later date)
Change an employee's address Note: May have a bearing on the employee's rate			X		This 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		Section 4 and the Notes section of the Small Group Employee Information Change Form must be completed
Request addition of Domestic Partner eligibility to group plan				X	Domestic Partner eligibility may only be added on the group's anniversary date
Change employer's address				X	You may also submit a written request on the employer's letterhead

SECTION 5 Membership Changes

Deleting Employees from the Plan

The Small Group Employee 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 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 20 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 2 of the Small Group Employee Information Change Form should be filled out completely. Please include employee or dependent names, certificate 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 of California 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 a letter from the group or by completing the Small Group Information Change Form. The notice should be faxed to (805) 499-7762 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 Employee Information Change Form or written notice 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: 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.

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

Retroactive terminations will not be accepted

Deleting Employees Who Remain Eligible but Discontinue Coverage

Please complete the following information on the Small Group Employee Information Change Form or submit a request on company letterhead: a certificate 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 cancelling coverage. This is in accordance with California State Law AB1672.

The employer must complete section 1 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.

Important Note: *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 will 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 4 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.

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 Employee 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.

Important Note: *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 payor 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 “Continuation of Coverage” subsection).

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
<p>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.</p>	<p>Letter from employee certifying these conditions have been met.</p>
<p>Incapable of self-sustaining support due to physical handicap or mental retardation.</p>	<p>Certification from attending physician that dependent is incapable of self-sustaining support due to physical handicap or mental retardation.</p>

SECTION 6 Group Requirements and Maintenance

Accuracy of Information

In order for Blue Cross to effectively administer benefits under your group policy, it is necessary for you to submit timely, accurate information on any eligibility changes. This information must be submitted in association with 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 responsibility of the employer to notify Blue Cross of changes that affect the group including, but not limited to, an address change for the company, change in ownership, 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, Certificates

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

Each employee will receive two identification cards reflecting the employee's name and coverage selected. Cards are not automatically generated for each dependent. Additional cards can be ordered through Membership. If an identification card is lost, misplaced or destroyed, replacement cards may be ordered by phone or written request.

If an employee selects an HMO 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.

Participation Requirements

Standard group participation requirement in the employee's Blue Cross group health plan is a minimum of 75% of eligible employees. The group participation requirement increases to a minimum of 80% of eligible employees if: (a) the employer selects a Defined Contribution financing option; (b) the employer selects two or more PPO plan options or the High Deductible EPO plan and one or more PPO plan options; and/or (c) the employer selects two HMO plan options.

No. of Employees	Financing Option	Minimum Required Participation
2 – 50	Traditional	75% of eligible employees*
2 – 50	Defined Contribution 100	80% of eligible employees
2 – 50	Defined Contribution 80	80% of eligible employees
2 – 50	Defined Contribution Select	80% of eligible employees
2 – 50 with medical coverage	Voluntary Dental plans	3 employees or 25% of eligible employees, whichever is greater

* Under the Traditional Contribution financing option, required participation increases to a minimum 80% of eligible employees if the employer chooses two or more PPO plan options OR the High Deductible EPO plan and one or more PPO plan options OR two HMO plan options.

Contribution Requirements

The group must maintain the corresponding minimum participation levels in order to remain eligible (or 100% if non-contributory). Groups are subject to non-renewal if participation falls below the required minimum.

Medical

Employers have the flexibility to choose their preferred approach for contributing towards employee health premiums. Employers must contribute one of the following:

- A minimum of 50% of the employee's monthly health premium (Traditional Contribution)
- \$100 per employee per month or the actual cost of policy (whichever is less) for the employee's health premium (Defined Contribution 100)
- \$80 per employee per month or the actual cost of policy (whichever is less) for the employee's health premium (Defined Contribution 80 – available only for certain plans)
- Any fixed dollar amount greater than \$100 per employee per month for the employee's health premium (Defined Contribution Select)

Payroll deduction is required if contributory.

Dental

Employers have the flexibility to choose their preferred approach for contributing towards employee dental premiums. Employers must contribute one of the following:

- A minimum of 50% of the employee's monthly dental premium (Traditional Contribution)
- \$15 per employee per month or the actual cost of policy (whichever is less) for the employee's dental premium (Defined Contribution 15)
- Any fixed dollar amount greater than \$15 per employee per month for the employee's dental premium (Defined Contribution Select)

Payroll deduction is required if contributory or:

- \$0 if offering Voluntary Dental plans – Voluntary Dental plans are 100% employee-paid and cannot be combined with Small Group Dental plans

Life

Employers must contribute a minimum of 25% of the employee's life premium. Payroll deduction is required if contributory.

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:

- Expand group eligibility to include Domestic Partners
- 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

Important Note: *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 15, 2002, then your anniversary date is February 1, 2002. Any group with an effective date prior to January 1, 1991 has been transitioned to a January 1, 1991 effective and anniversary date.*

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.

Important Note: *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.***

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 officer of the company. The change, if approved, will be effective on the first of the month following receipt of the employer's request.

Important Note: *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.

Important Note: *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 Employee Information Change Form. Once coverage ends, the employee may have the option to continue coverage under either COBRA or Cal-COBRA benefits (see "Continuation of Coverage" subsection).

Cancelling 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 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. 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 changes. 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.

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.

Important Note: *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.

Important Note: *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 or life plan
- Changing to a different medical, dental or life plan
- Changing contribution approach
- Review of the group's Risk Adjustment Factor (RAF)
- Adding Workers' Compensation insurance
- Adding Domestic Partners, 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 Benefit Modification Requirements Matrix 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 (on the following page). 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 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.

Important Note: *Moving to a less expensive plan will most likely result in less coverage. Moving to a more expensive plan will usually result in more coverage. Requests to change to a more expensive plan will usually require underwriting approval. Requests to move to more affordable plans usually do not require underwriting approval*

Small Group Guide to Plan Change Underwriting

		Premier PPO		Blue Cross HMO		PPO Copay Plans			EPO	PPO	
Move To ▶	Move From ▼	\$10 Copay	\$20 Copay	HMO 100%	Saver HMO	Advantage \$25 Copay	\$30 Copay	\$40 Copay	High Deductible EPO (MSA Compatible)	Saver PPO	Basic PPO
Premier PPO	\$10 Copay		N	Y	N	N	N	N	N	N	N
	\$20 Copay	Y		Y	N	N	N	N	N	N	N
Blue Cross HMO	HMO 100%	Y	Y		N	N	N	N	N	N	N
	Saver HMO	Y	Y	Y		N	N	N	N	N	N
PPO Copay Plans	Advantage \$25 Copay	Y	Y	Y	Y		N	N	N	N	N
	\$30 Copay	Y	Y	Y	Y	Y		N	N	N	N
	\$40 Copay	Y	Y	Y	Y	Y	Y		N	N	N
EPO	High Deductible EPO (MSA Compatible)	Y	Y	Y	Y	Y	Y	Y		N	N
PPO	Saver PPO	Y	Y	Y	Y	Y	Y	Y	Y		N
	Basic PPO	Y	Y	Y	Y	Y	Y	Y	Y	Y	

How to Use the Small Group Guide to Plan Change Underwriting

1. Identify your current plan in the left vertical column.
2. Identify the plan you are interested in moving to along the top row.
3. Follow each line to their meeting point. If the box indicates a “Y,” the change will require underwriting approval. “N,” indicates that no underwriting approval is required.

Y = Yes, underwriting approval is required. *Underwriting is usually required when a request is made to move to a plan with greater coverage.*

N = No underwriting approval is required. *Usually, no underwriting is required when a request is made to move to a plan with lesser coverage.*

Please note: When you move to a less expensive plan, you may also be moving to a plan with less coverage.

Benefit Modification Requirements

<i>Benefit Modification</i>	<i>When Eligible</i>	<i>Documents Necessary</i>
ADD MEDICAL BENEFITS Includes increasing number of plans offered under existing Blue Cross health coverage OR REQUEST A CHANGE IN MEDICAL BENEFITS THAT REQUIRES UNDERWRITING Refer to Matrix on previous page; Where at least one plan offered under existing Blue Cross health coverage is changed	Six months after original effective date, once in a 12-month period	1. Employer Application 2. Letter from Group 3. Change of Coverage Application for those employees requesting to change 4. DE-6 (Subject to underwriting approval)
REQUEST A CHANGE IN MEDICAL BENEFITS THAT DOES NOT REQUIRE UNDERWRITING Refer to Matrix on previous page	Six months after original effective date, once in a 12-month period	1. Employer Application 2. Letter from Group 3. DE-6
CHANGE IN CONTRIBUTION OPTION	Six months after original effective date, once in a 12-month period	1. Employer Application 2. Letter from Group 3. DE-6 (Subject to underwriting approval)
ADD PART-TIME EMPLOYEE ELIGIBILITY	On anniversary date	1. Employer Application 2. Letter from Group 3. DE-6 4. 2-50 Existing Small Group Employee Addition Application requesting or declining coverage on ALL eligible part-time employees
ADD LIFE INSURANCE OR INCREASE EXISTING COVERAGE Existing groups choosing to add life insurance or increase existing life insurance coverage, are subject to full medical underwriting, regardless of group size. (No rate guarantee will apply)	First of the month following receipt of all documentation	1. Employer Application 2. Letter from Group 3. New applications for all enrollees 4. DE-6 (Subject to underwriting approval)
ADD DENTAL PPO 2-50, Dental Net 2-50 Dental SelectHMO 2-50 (No rate guarantee will apply) (Proof of prior coverage required for waiting period credit.)	First of the month following receipt of all documentation	1. Employer Application 2. Letter from Group 3. Dental applications for all employees 4. DE-6 (Subject to underwriting approval)
ADD VOLUNTARY DENTAL Group size 2-50 with medical coverage* * Requires a minimum of 3 employees or 25% participation of eligible employees, whichever is greater, in either or both Voluntary PPO and HMO medical plans	First of the month following receipt of all documentation	1. Employer Application 2. Letter from Group 3. DE-6
RISK ADJUSTMENT FACTOR CHANGE AB1672 Group size 2-4; 1.0 is best rate AB1672 Group size 5-50; .95 is best rate Note: No more than 10% reduction of rates will be given	On anniversary date	1. Employer Application 2. Letter from Group 3. Change of Coverage Applications for all enrollees 4. DE-6 (Subject to underwriting approval)
ADD WORKERS' COMPENSATION	Anytime	1. Letter from Group 2. Contact Fremont Underwriting (800) 662-2733
ADD DOMESTIC PARTNER ELIGIBILITY	On anniversary date	1. Employer Application 2. Letter from Group 3. 2-50 Existing Small Group Employee Addition Application requesting or declining coverage on all eligible Domestic Partners (Declaration of Domestic Partnership) 4. DE-6

Continuation of Coverage

Important Note: When a member's 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
- 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 Change Notification 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 Employee 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.

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 Change Notification to notify Blue Cross that an employee has elected to continue coverage under COBRA. Complete section 1 to report termination of the employee and complete section 2 to notify Blue Cross that the employee has opted to continue benefits under COBRA. Both sections 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 his/her option to extend coverage under Cal-COBRA for up to 36 months. This letter will also inform him/her of applicable Cal-COBRA rates. The COBRA member will need to respond to the notice, indicating whether he/she wishes to extend coverage under Cal-COBRA.

HIPAA

Terminated employees and/or their dependents and employees and/or their dependents 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.

The employer is responsible for informing eligible employees and their dependents of the conversion option. Members must make a request for a Conversion Benefit Agreement within 31 days of becoming ineligible or exhausting previous coverage.

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 any of the following occur:

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

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 back of 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.

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

SECTION 8 Wellness Programs

Wellness Programs

Blue Cross of California 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 the Blue Cross of California 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 of California 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.

Available with: HMO, PPO and EPO.

MedCall[®]

The Blue Cross 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, Blue Cross MedCall at (800) 249-3617 is here for you.

Available with: HMO, PPO, EPO.

HealthyCheckSM

Blue Cross offers 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.

Available with: PPO (except Basic PPO) and EPO.

Health Management Programs

Blue Cross of California's Health Management Programs provide members who have chronic conditions with the tools they need 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 management programs, call toll-free at (800) 522-5560.

Available with: HMO, PPO and EPO.

Blue Cross Baby ConnectionSM

The Blue Cross 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.

Available with: HMO, PPO and EPO.

BlueCard[®]

The BlueCard program allows PPO members who need care when traveling outside of California to enjoy the benefits of Blue Cross of California 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).

Available with: PPO.

Ordering Forms

Blue Cross provides, at no charge, necessary forms and brochures for you to properly administer your group plan. Forms can be viewed and/or printed from our Web site at www.bluecrossca.com. Click on “Employers,” then click on “Groups with 2-50 Employees” and then click on “Forms.” The following is a list of forms available on our Web site:

- 2-50 Small Group Employer Application
- 2-50 Small Group Employee Application
- 2-50 Existing Small Group Employee Addition Application
- Small Group Change of Coverage Application
- Dental Coverage Employee Application
- Small Group Benefit Modification Inquiry
- Small Group Employee Information Change Form
- Exception to Standard Enrollment Form/Translator’s Statement
- Patient Claim Form
- Affidavit of Domestic Partnership
- Cal-COBRA/COBRA and Medicare Survey
- Small Group Required Information Checklist
- Accelerated Death Benefit Attending Physician’s Statement
- Claim for Personal Accelerated Death Benefit
- Beneficiary Claim Form & Group Policyholder’s Statement
- Absolute Assignment
- Life Enrollment for Existing Employees and/or Beneficiary Designation Form
- Statement of Attending Physician (Dismemberment)

You may also request forms to be faxed or mailed to you (including large quantity orders) by calling Customer Service at (800) 627-8797 or forms may be requested by completing a Supply Request Form for Small Group Business (IS 2081SG). Your order will be filled with the most recent version of the form or brochure requested.

To maintain adequate inventories, we must receive 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. Send your request to the address or fax number listed on the form. Blue Cross will occasionally update required forms for adding employees to or deleting them from the group. The employer is responsible for maintaining an inventory of the most recent versions of enrollment and maintenance forms, which can always be obtained from the Blue Cross Web site at www.bluecrossca.com. Submission of old, out-of-date forms may delay your requests.

Life Insurance (BC Life & Health Insurance Company)

(This section is applicable only if your group chose to include life insurance in your Small Group benefit 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 a copy of the bill to the address below:

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

Important Note: Do not adjust your bill to reflect changes in membership. Report changes on the Small Group Employee Information Change Form (0005063). 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 of this manual for information on when applications must be received).

Changing Coverage

If your group benefit package provides for more than one level of life insurance, it is the employer's responsibility to inform Blue Cross on a timely basis. Any change in an employee's status that will result in a change in benefit levels, whether it is an increase or decrease in coverage, must be reported to Blue Cross. To change benefit levels for an employee, submit a new Employee Application when an employee's job classification or salary changes, whichever is applicable to your plan.

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 Employee Information Change Form (0005063). Do not submit the Small Group Employee Information Change Form 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 below) 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.

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

Required Information Checklist

Note: Forms can be viewed and/or printed from our Web site at www.bluecrossca.com (see the Forms/Supplies section of this manual for a list of forms available online). Click on "Employers," then click on "Groups with 2-50 Employees" and then click on "Forms." You may also request forms to be faxed or mailed to you by calling Customer Service at (800) 627-8797 or forms may be requested by completing a Supply Request Form for Small Group Business (IS 2081SG).

IF YOUR INQUIRY CONCERNS:

- **Change in Beneficiary Designation or Name Change**

Complete the Life Enrollment for Existing Employees and/or Beneficiary Designation Form (WL4004).

Note: The change of beneficiary will not become effective until it is received by BC Life & Health. Beneficiary changes received after the submission of a claim will not be processed.

Mail the appropriate form to:

BC Life & Health Insurance Company
Small Group Services
P.O. Box 9062
Oxnard, CA 93031-9062

IF YOUR INQUIRY CONCERNS:

- **Request for Life Insurance Conversion**

Complete the Request for Conversion Information Form (WL2002).

Note: If an employee becomes ineligible for group Life/AD&D insurance or a portion thereof because of termination of employment, retirement, a reduction in benefit amount or any other reason, a conversion of insurance from group insurance to whole life insurance is available. To exercise this privilege, the employer and employee must complete form WL2002. The completed form, in addition to premium payment, must be received by BC Life & Health within 31 days of termination of employment, reduction in benefit amount or retirement.

Mail the appropriate form to:

BC Life & Health Insurance Company
Specialty Finance Department AC12A
21555 Oxnard Street
Woodland Hills, CA 91367

Important Note: *It is the employer's responsibility to notify employees of their right to convert life benefits.*

IF YOUR INQUIRY CONCERNS:

• **Claim for Death Benefits**

- Complete the Beneficiary Claim Form & Group Policyholder's Statement Form (0003366).

Note: The employer is responsible for submitting a life claim upon the death of an insured employee.

• **Absolute Assignment**

- Complete the Absolute Assignment Form (WL4005).

Note: Absolute Assignment allows the employee to assign the sole right of ownership to a named assignee(s), including privileges and rights to beneficiary designation. An employee seeking to assign sole right of ownership for his/her life insurance policy must complete form WL4005 and send it to BC Life & Health.

• **Claim for Accelerated Death Benefit**

- Employer and employee complete the Claim for Personal Accelerated Death Benefit Form (0003365)
- Attending physician completes the Accelerated Death Benefit Attending Physician's Form (0003364)

• **Claim for Dismemberment or Eye Loss**

- Employee completes the Affidavit of Claimant Form (WL2006)
- Employer completes the Certificate of Employer or Superior Officer Form (WL2008)
- Employee's doctor completes the Statement of Attending Physician:
 - Dismemberment Form (WL2007)
 - Eye Loss Form (WL2009)

• **Claim for Waiver of Premium**

- Attending physician, policyholder and insured complete the Total Disability Claim Form for Group Life Insurance – Waiver of Premium Form (WL2004)

Note: If an employee becomes completely disabled prior to age 60 and remains totally and continuously disabled, BC Life & Health 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 (WL 2004) 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 BC Life & Health 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.

Mail the appropriate form(s) to:
BC Life & Health Insurance Company
Life Claims Unit
1350 Main Street
Springfield, MA 01103-1650

Important Note: *It is the employer's responsibility to notify employees of their right to waiver of premium benefits.*

SECTION 11 Workers' Compensation

Workers' Compensation

(Through Fremont Employers and Affiliated Companies)

Fremont Employers and Affiliated Companies ("FEAAC"), through its subsidiary, the Fremont General Insurance Agency, Inc., is offering quotes from Harbor Specialty Insurance Company. Harbor Specialty is a member of the Clarendon Insurance Group, rated "A" (Excellent) IX by A.M. Best. All services for Harbor Specialty policies will be provided by FEAAC.

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 of California 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 of California premium payment and the Workers' Compensation payment. Please indicate on the coupon how much of your payment is for Blue Cross of California and how much is for Workers' Compensation so that we can correctly apply your payment.

How to Cancel

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

Fremont Employers and Affiliated Companies
P.O. Box 9057
Oxnard, CA 93031

Integrated MediComp Discounts

All Fremont Employers and Affiliated Companies 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 discount is subject to underwriting approval.

Important Note: *Workers' Compensation is provided under policies issued by Harbor Specialty Insurance Company or other carriers through Fremont Employers 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

Important Note: To report a claim, please contact Fremont Compensation's 24-hour toll-free Claims Reporting Service at (877) 258-3824.

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.

Important Note: Claims kits are only sent with the initial policy. If a new claims kit or additional kits are needed, contact Fremont Compensation 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 Fremont. 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 Fremont Employers' 24-hour Claims Reporting Service at (877) 258-3824 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. Fremont Employers will give written confirmation of receipt of your telephone report, as well as a completed 5020 form by your choice of fax or mail.

SECTION 12 P.O.P., FSA and COBRA Administration

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.

Important Note: 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 CobraServ service is available to assist busy small group administrators to relieve some of the confusion that comes with COBRA administration. CobraServ is a comprehensive service that 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

Blue Cross of California (BCC) and BC Life & Health (BCL&H) Insurance Company are Independent Licensees of the Blue Cross Association (BCA). The Blue Cross name and symbol are registered service marks of the BCA.

Dental Net, Blue Cross Dental SelectHMO and all medical products except Basic PPO, Saver PPO and Advantage PPO are offered by BCC. Blue Cross PPO and FFS Dental, Basic PPO, Saver PPO, Advantage PPO, Term Life and AD&D Products are offered by BCL&H.

Workers' Compensation coverage is provided through Fremont Employers and Affiliated Companies. Workers' Compensation insurance policies to be issued by Harbor Specialty Insurance Company or Fremont Employers Insurance Company.

**Blue Cross of California
Small Group Services
P.O. Box 9062
Oxnard, CA 93031-9062
(800) 627-8797**

www.bluecrossca.com

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