Master Group Application (for 51+ employees)

blue of california

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

Group number: _____

Plans for 51+ employees
Medical benefits without ABHP (account based health plan) plan options:

- ☐ Access+ HMO _____
- ☐ Access+ HMO SaveNet _____
- ☐ Local Access+ HMO _____
- ☐ Trio ACO HMO
- ☐ Active Choice®[1] _____
- ☐ Added Advantage POS
- ☐ Full PPO _____
- ☐ Full PPO HSA[2] _____

Medical benefits with ABHP (account-based health plan) plan options:

Access+ HMO: ☐ HRA ☐ HIA ☐ FSA
Local Access+ HMO: ☐ HRA ☐ HIA ☐ FSA
Full PPO: ☐ HRA ☐ HIA ☐ FSA
Full PPO HSA[2]: ☐ HRA ☐ HIA ☐ HSA ☐ LFSA[3]

51-100 Small Group Transition plans:
☐ HMO ☐ PPO ☐ Full PPO HSA

ABHP benefit options for above plans:
For HMO: ☐ HRA ☐ HIA ☐ FSA
For PPO: ☐ HRA ☐ HIA ☐ FSA
For Full PPO HSA[2]: ☐ HSA ☐ HRA ☐ HIA ☐ LFSA[3]

Specialty Benefits

- ☐ Basic group Term life/AD&D insurance[1]
- ☐ Dependent basic life insurance[1]
- ☐ Supplemental life insurance[1]
- ☐ Supplemental AD&D insurance[1]
- ☐ Dental PPO _____
- ☐ Dental INO[1] _____
- ☐ Dental HMO _____
- ☐ Vision _____
- ☐ Other _____

1 Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).
2 Full PPO HSA is HSA-eligible high-deductible health plans.
3 Must be paired with an HSA plan only.
Note: Blue Shield does not offer tax advice, and offers tax advantage accounts through HealthEquity.

Please type or print clearly. Use black ink.

1 How will individuals be enrolled? ☐ Paper enrollment ☐ Web portal/electronic enrollment

2 Group's full legal business name

Requested effective date of coverage (month/day/year):

3 Billing address

City | State | ZIP code

4 Physical address (if different from above) | County location of physical address

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A. Group contact name	B. Job title	C. Group contact for:	D. Phone No.	E. Fax No.	F. Email address
		Primary group contact			
		Online administrator contact			
		Billing contact			
		Evidence of Coverage/ Certificate of Insurance (EOC/COI) contact			

G. Federal employer tax ID number _____ **Does the group have multiple tax ID numbers?** ☐ Yes ☐ No
If Yes, provide the Federal employer tax ID number for the plan sponsor. _____

6 Legal entity type: ☐ Corporation ☐ Partnership ☐ Sole proprietorship ☐ Other (specify) _____

7 Type of business (provide as much detail as possible):

Major industries and products/services of the group's business _____

Standard industry classification code(s) (SIC code) in which the business is classified _____

8 List subsidiary or affiliated companies by name(s) and address(es)requesting to be included in the coverage.

If no subsidiary/affiliated companies apply, check "N/A." ☐ N/A

9 Prior group health carrier(s) (If prior carrier was Blue Shield, please note)

Do you offer other carriers' health plans to your employees? ☐ Yes ☐ No If Yes, list carrier name(s):

Initial effective date of coverage (month/day/year):

10 Effective date following employer waiting period: The group may select from one of the following options for coverage to begin following any waiting period it has established. Coverage for eligible employees will become effective following completion of the waiting period on the day specified:

☐ Effective first of month following date of hire (If hired on the 1st of the month, coverage will be effective the 1st of the following month)

☐ Effective first of month following 30 days from date of hire

☐ Effective first of the month following 60 days from date of hire

☐ Effective on the 91st day following date of hire

If there are multiple waiting periods based on classification, please indicate as appropriate:

☐ Coverage effective on the first of the month following date of hire (Example: Employee hired 12/15/14 is effective 1/1/15)
- ☐ All employees
- ☐ Other (please describe): _____

☐ Coverage effective first of the month following 30 days from date of hire (Example: Employee hired 12/15/14 is effective 1/1/15)
- ☐ All employees
- ☐ Other (please describe): _____

☐ Coverage effective first of the month following 60 days from date of hire (Example: Employee hired 12/15/14, julian date is 349, add 60 days and effective date is 2/14/15)
- ☐ All employees
- ☐ Other (please describe): _____

☐ Coverage effective on the 91st day following date of hire (Example: Employee hired 12/15/14, julian date is 349, add 90 days and effective date is 3/15/15)

☐ Other:_____

Please explain any exceptions to the waiting period. (Example: Waiting period is waived for executives)

_____

Will the waiting period be waived:	Retro add/term changes allowed:
☐ Yes ☐ No For current, actively at-work employees	☐ Within 30 days plus current month
☐ Yes ☐ No For part-time employees upon attaining full-time status	☐ Within 60 days plus current month
☐ Yes ☐ No For employees rehired within ☐ 6 months ☐ _____ of termination date	☐ Within 90 days plus current month

Subscriber termination options ☐ Coverage will end on the date employment terminates
☐ Coverage will end on the last day of the month in which employment terminates

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Total number of employees (full and part time)	Total number of eligible employees	Number of full-time employees in waiting period: _____ Number of employees who are declining coverage: _____

Are there any out-of-state employees? ☐ Yes ☐ No

How many out-of-state employees do you have? _____

Do you wish to offer coverage to your out-of-state employees? ☐ Yes ☐ No

If yes, please indicate the state(s) employees reside in:

_____

Employer is responsible for collecting and retaining Refusal of Coverage Forms, and providing to Blue Shield upon request. If no Blue Shield medical plan is offered (e.g., dental, vision, or life insurance only) Refusal of Coverage Forms are not required.

12 A. Are all full-time eligible employees being offered health coverage? ☐ Yes ☐ No If No, please explain:

B. Are all full-time eligible employees being offered health coverage actively working at least 30 hours per week?
☐ Yes ☐ No If No, please explain:

C. Will the group offer coverage to permanent employees who work an average of 20-29 hours per week? ☐ Yes ☐ No

D. Are retirees eligible for benefits? ☐ Yes ☐ No Note: Retiree coverage option requires prior underwriting approval
If Yes, please check any that apply:
☐ Early retirees under age 65
☐ Retirees 65 years and over (Attach a copy of both Medicare Part A and B cards for installation. For paper applications only.)
Will you contribute to retiree coverage? ☐ Yes ☐ No

E. Will the group offer Medicare Part D options? ☐ Yes ☐ No If Yes, please check any that apply:
☐ Retirees only ☐ Actives and retirees ☐ Enhanced PDP ☐ Retiree drug subsidy ☐ Blue Shield 65 Plus

F. Age of dependent children: Dependent children are eligible if less than 26 years of age. Children age 26 or older, who are currently covered as a dependent due to a physical or mental disabling injury or illness, are not subject to any age restrictions and are eligible for coverage with documentation.

13 Domestic partner coverage (check one) – Domestic partners must also meet Blue Shield's dependent eligibility requirements as applicable and as defined in the contract.

☐ 1. Narrow coverage: California state registered (both partners have filed a Declaration of Domestic Partnership with the state of California. Both partners must be the same sex. Opposite-sex partners allowed if one partner is at least 62 and eligible for Social Security).

☐ 2. Broad coverage: California state registration not required (both partners may be the same or opposite sex).

14 A. Employer contribution for Blue Shield health plans – Enter percentage of premium paid by the group for employees and dependents. If the group contributes 100%, then all eligible employees must enroll.

Access+ HMO plans	**Active Choice plans***	**Added Advantage POS plans**	**Access+ HMO SaveNet plans**
For employees _____ %	For employees _____ %	For employees _____ %	For employees _____ %
For dependents _____ %	For dependents _____ %	For dependents _____ %	For dependents _____ %
For retirees (if applicable) _____ %	For retirees (if applicable) _____ %	For retirees (if applicable) _____ %	For retirees (if applicable) _____ %
For retirees' dependents (if applicable) _____ %	For retirees' dependents (if applicable) _____ %	For retirees' dependents (if applicable) _____ %	For retirees' dependents (if applicable) _____ %
Local Access+ HMO plans	**Full PPO HSA plans**	**Blue Shield 65 Plus plans**	**Full PPO plans**
For employees _____ %	For employees _____ %	For employees _____ %	For employees _____ %
For dependents _____ %	For dependents _____ %	For dependents _____ %	For dependents _____ %
For retirees (if applicable) _____ %	For retirees (if applicable) _____ %	For retirees (if applicable) _____ %	For retirees (if applicable) _____ %
For retirees' dependents (if applicable) _____ %	For retirees' dependents (if applicable) _____ %	For retirees' dependents (if applicable) _____ %	For retirees' dependents (if applicable) _____ %
TRIO ACO HMO plans			
For employees _____ %			
For dependents _____ %			
For retirees (if applicable) _____ %			
For retirees' dependents (if applicable) _____ %			

Dental plans with required employer contribution
Indicate dental contribution amount here:
For employees _____ **%**
For dependents _____ **%**
For retirees (if applicable) _____ %
For retirees' dependents (if applicable) _____ %

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

Vision plans
For employees _____ %
For dependents _____ %
For retirees (if applicable) _____ %
For retirees' dependents (if applicable) _____ %

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

† A voluntary vision plan requires a minimum of 10 enrolling employees with Blue Shield Life medical coverage or 25% of eligible employees if without Blue Shield Life coverage.

15	51-100 Small Group Transition plans			
	Platinum Access+ HMO® $25 For employees _____ % For dependents _____ % For retirees (if applicable) _____ % For retirees' dependents (if applicable) _____ %	**Gold Access+ HMO® $30** For employees _____ % For dependents _____ % For retirees (if applicable) _____ % For retirees' dependents (if applicable) _____ %	**Silver Access+ HMO® $55** For employees _____ % For dependents _____ % For retirees (if applicable) _____ % For retirees' dependents (if applicable) _____ %	**Gold Full PPO 0** For employees _____ % For dependents _____ % For retirees (if applicable) _____ % For retirees' dependents (if applicable) _____ %
	Gold Full PPO 750 For employees _____ % For dependents _____ % For retirees (if applicable) _____ % For retirees' dependents (if applicable) _____ %	**Silver Full PPO 1250** For employees _____ % For dependents _____ % For retirees (if applicable) _____ % For retirees' dependents (if applicable) _____ %	**Platinum Full PPO 150** For employees _____ % For dependents _____ % For retirees (if applicable) _____ % For retirees' dependents (if applicable) _____ %	**Bronze Full PPO HSA 5500** For employees _____ % For dependents _____ % For retirees (if applicable) _____ % For retirees' dependents (if applicable) _____ %
	Silver Full PPO HSA 2000 For employees _____ % For dependents _____ % For retirees (if applicable) _____ % For retirees' dependents (if applicable) _____ %	**Silver Full PPO 1700** For employees _____ % For dependents _____ % For retirees (if applicable) _____ % For retirees' dependents (if applicable) _____ %	**Platinum Local Access+ HMO® $25** For employees _____ % For dependents _____ % For retirees (if applicable) _____ % For retirees' dependents (if applicable) _____ %	**Gold Local Access+ HMO®** For employees _____ % For dependents _____ % For retirees (if applicable) _____ % For retirees' dependents (if applicable) _____ %
	Silver Local Access+ HMO® $55 For employees _____ % For dependents _____ % For retirees (if applicable) _____ % For retirees' dependents (if applicable) _____ %	**Platinum Full PPO 0** For employees _____ % For dependents _____ % For retirees (if applicable) _____ % For retirees' dependents (if applicable) _____ %	**Bronze Full PPO 4500** For employees _____ % For dependents _____ % For retirees (if applicable) _____ % For retirees' dependents (if applicable) _____ %	**Bronze Full PPO HSA 4500** For employees _____ % For dependents _____ % For retirees (if applicable) _____ % For retirees' dependents (if applicable) _____ %
	Basic Group Term life/ accidental death & dismemberment (AD&D) insurance For employees _____ % For dependents _____ % For retirees (if applicable) _____ % For retirees' dependents (if applicable) _____ % **For life insurance coverage, the employer must contribute a minimum of 25% of the total employee's premium. If 100% is paid, all eligible employees must enroll.**			

16 Blue Shield Account Based Health Plans (ABHP)

Indicate if you are offering any of the following account options (check all that apply) and provide the name of the administrator of each program. Also indicate _____ any amount to be funded by employer contribution.

Account type	Account administrator	Employer contribution amount individual coverage	Employer contribution amount family coverage
☐ Health Savings Account (HSA)	☐ HealthEquity (integrated model – Blue Shield shares eligibility & claims) ☐ Other administrator (non- integrated option)	$	$
☐ Health Reimbursement Arrangement (HRA)	☐ HealthEquity (integrated model – Blue Shield shares eligibility & claims) ☐ Other administrator (non- integrated option)	$	$
☐ Health Incentive Account (HIA) – add Wellverse Wellness Program – minimum 50 participants	☐ HealthEquity (integrated model – Blue Shield shares eligibility & claims) ☐ Other administrator (non- integrated option)	$	$
☐ Limited Purpose Flexible Spending Account (LFSA – Dental & Vision) with HSA only	☐ HealthEquity (integrated model – Blue Shield shares eligibility & claims) ☐ Other administrator (non- integrated option)	$	$
☐ Flexible Spending Account (FSA) ☐ Medical FSA ☐ Dependent Care FSA	☐ HealthEquity (integrated model – Blue Shield shares eligibility & claims) ☐ Ceridian (manual feed) ☐ Other administrator (non- integrated option)	$	$

17 Are all employees covered by workers' compensation to the extent required by law?

☐ Yes Carrier name: _____

☐ No If No, please explain: _____

18 Are any employees or COBRA/Cal-COBRA participants enrolling in a Blue Shield plan currently not working (if employee of the group), disabled, or hospitalized? ☐ Yes ☐ No If yes, complete Disability Addendum (form C11248).

Name of COBRA administrator: _____

19 Your group is subject to federal COBRA if you employed 20 or more employees during at least 50% of the working days in the previous calendar year. The group is solely responsible for all aspects of the administration of Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA).

How many existing Cobra or Cal-COBRA participants do you have? _____ How many in eligibility period? _____

20 Is the group subject to ERISA? ☐ Yes ☐ No

21 Department Codes – Please list:

Blue Shield of California Medical plan selection

22 **Access+ HMO plans**

- ☐ Access+ HMO Zero Admit 10
- ☐ Access+ HMO Zero Admit 20
- ☐ Access+ HMO Zero Admit 30
- ☐ Access+ HMO Per Admit 10-250
- ☐ Access+ HMO Per Admit 25-750
- ☐ Access+ HMO Per Admit 40-1000
- ☐ Access+ HMO Per Admit 20-500
- ☐ Access+ HMO 20-250/Admit Inpatient
- ☐ Access+ HMO Facility Coinsurance 15-20%
- ☐ Access+ HMO Facility Coinsurance 20-20%
- ☐ Access+ HMO Facility Coinsurance 25-25%
- ☐ Access+ HMO Facility Coinsurance 40-40%
- ☐ Access+ HMO Facility Coinsurance 45-50%
- ☐ Access+ HMO Facility Deductible 15-10%/1500[4]
- ☐ Access+ HMO Facility Deductible 20-25%/1500
- ☐ Access+ HMO Facility Deductible 30-30%/2000
- ☐ Access+ HMO Facility Deductible 40-40%/2000
- ☐ Custom plan (attach custom menu)

23 **Access+ HMO SaveNet plans[1]**

- ☐ Access+ HMO SaveNet Zero Admit 10
- ☐ Access+ HMO SaveNet Zero Admit 20
- ☐ Access+ HMO SaveNet Zero Admit 30
- ☐ Access+ HMO SaveNet Per Admit 10-250
- ☐ Access+ HMO SaveNet Per Admit 20-500
- ☐ Access+ HMO SaveNet Per Admit 25-750
- ☐ Access+ HMO SaveNet Per Admit 40/1000
- ☐ Access+ HMO SaveNet Facility Coinsurance 15-20%
- ☐ Access+ HMO SaveNet Facility Coinsurance 20-20%
- ☐ Access+ HMO SaveNet Facility Coinsurance 25-25%
- ☐ Access+ HMO SaveNet Facility Coinsurance 40-40%
- ☐ Access+ HMO SaveNet Facility Coinsurance 45-50%
- ☐ Access+ HMO SaveNet Facility Deductible 15-10%/1500
- ☐ Access+ HMO SaveNet Facility Deductible 20-25%/1500
- ☐ Access+ HMO SaveNet Facility Deductible 30-30%/2000
- ☐ Access+ HMO SaveNet Facility Deductible 40-40%/2000
- ☐ Access+ HMO SaveNet 15-500 Per Admit Inpatient
- ☐ Access+ HMO SaveNet 10-50% Zero Facility Deductible
- ☐ Custom plan (attach custom menu)

24 **Local Access+ HMO plans**[3]

- ☐ Local Access+ HMO Zero Admit 10
- ☐ Local Access+ HMO Zero Admit 20
- ☐ Local Access+ HMO Zero Admit 30
- ☐ Local Access+ HMO Per Admit 10-250
- ☐ Local Access+ HMO Per Admit 20-500
- ☐ Local Access+ HMO Per Admit 25-750
- ☐ Local Access+ HMO Per Admit 40-1000
- ☐ Local Access+ HMO Facility Deductible 15-10%/1500
- ☐ Local Access+ HMO Facility Deductible 20-25%/1500
- ☐ Local Access+ HMO Facility Deductible 30-30%/2000
- ☐ Local Access+ HMO Facility Deductible 40-40%/2000
- ☐ Local Access+ HMO Facility Coinsurance 15-20%
- ☐ Local Access+ HMO Facility Coinsurance 20-20%
- ☐ Local Access+ HMO Facility Coinsurance 25-25%
- ☐ Local Access+ HMO Facility Coinsurance 40-40%
- ☐ Local Access+ HMO Facility Coinsurance 45-50%

25 **51-100 Small Group Transition plans**[4,6]

- ☐ Platinum Access+ HMO® for $25
- ☐ Gold Access+ HMO® $30
- ☐ Silver Access+ HMO® $55
- ☐ Gold Local Access+ HMO® $30
- ☐ Silver Local Access+ HMO® $55
- ☐ Platinum Local Access+ HMO® 25
- ☐ Platinum Full PPO 0
- ☐ Platinum Full PPO 150
- ☐ Gold Full PPO 0
- ☐ Gold Full PPO 750
- ☐ Silver Full PPO 1250
- ☐ Silver Full PPO 1700
- ☐ Bronze Full PPO 4500
- ☐ Silver Full PPO HSA 2000
- ☐ Bronze Full PPO HSA 3500
- ☐ Bronze Full PPO HSA 5500
- ☐ Custom plan (attach custom menu)

26 **Added Advantage POS plans**

- ☐ Added Advantage POS 250-100/80/50
- ☐ Added Advantage POS 300-100/90/70 Premier
- ☐ Added Advantage POS 300-100/90/70 Standard
- ☐ Added Advantage POS 300-100/70
- ☐ Added Advantage POS 300-100/80/60
- ☐ Added Advantage POS 500-100/80/60
- ☐ Custom plan (attach custom menu)

27 **Trio ACO HMO plans**

- ☐ Trio ACO HMO Zero Admit 10
- ☐ Trio ACO HMO Zero Admit 20
- ☐ Trio ACO HMO Zero Admit 30
- ☐ Trio ACO HMO Per Admit 10-250
- ☐ Trio ACO HMO Per Admit 25-750
- ☐ Trio ACO HMO Per Admit 40-1000
- ☐ Trio ACO HMO Per Admit 20-500
- ☐ Trio ACO HMO Facility Coinsurance 15-20%
- ☐ Trio ACO HMO Facility Coinsurance 20-20%
- ☐ Trio ACO HMO Facility Coinsurance 25-25%
- ☐ Trio ACO HMO Facility Coinsurance 40-40%
- ☐ Trio ACO HMO Facility Coinsurance 45-50%
- ☐ Trio ACO HMO Facility Deductible 15-10%/1500
- ☐ Trio ACO HMO Facility Deductible 20-25%/1500
- ☐ Trio ACO HMO Facility Deductible 30-30%/2000
- ☐ Trio ACO HMO Facility Deductible 40-40%/2000

28 **Full PPO plans** – Choose deductible and copayment:

- ☐ Full PPO 250-80/60 Standard
- ☐ Full PPO 250-90/70 Premier
- ☐ Full PPO 250-90/70 Value
- ☐ Full PPO 250-80/60
- ☐ Full PPO Combined Deductible 10-0 100/50
- ☐ Full PPO Combined Deductible 15-150 90/70
- ☐ Full PPO Combined Deductible 20-200 90/70
- ☐ Full PPO Combined Deductible 25-250 90/60
- ☐ Full PPO Combined Deductible 30-500 90/60
- ☐ Full PPO Combined Deductible 35-500 80/60
- ☐ Full PPO Split Deductible 10-250 90/70
- ☐ Full PPO Split Deductible 15-500 90/60
- ☐ Full PPO Split Deductible 20-500 80/60
- ☐ Full PPO Split Deductible 25-750 80/60
- ☐ Full PPO Split Deductible 35-1000 80/60
- ☐ Full PPO Combined Deductible Value15-1500 80/50
- ☐ Full PPO Combined Deductible Value20-2000 80/50
- ☐ Full PPO Combined Deductible Value25-2500 80/50
- ☐ Full PPO Combined Deductible Value30-3000 80/50
- ☐ Full PPO Combined Deductible Value35-3500 80/50
- ☐ Full PPO Combined Deductible Value40-4000 80/50
- ☐ Custom plan (attach custom menu)

29 **Full PPO HSA plans**[4,5]

- ☐ Full PPO HSA Aggregate Deductible 1300/2600
- ☐ Full PPO HSA Aggregate Deductible 1500/3000
- ☐ Full PPO HSA Aggregate Deductible 1800/3600
- ☐ Full PPO HSA Aggregate Deductible 2250/4500
- ☐ Full PPO HSA Individual Member Deductible 2600
- ☐ Full PPO HSA Individual Member Deductible 3000
- ☐ Full PPO HSA Individual Member Deductible 3500
- ☐ Full PPO HSA Individual Member Deductible 4000
- ☐ Full PPO HSA Individual Member Deductible 5500
- ☐ Custom plan (attach custom menu)

Section A (C17607) – Blue Shield Life medical plans*

- ☐ Active Choice Plan 500
- ☐ Active Choice Plan 750
- ☐ Active Choice Plan 750 70/50
- ☐ Active Choice Plan 750 1000 Deductible
- ☐ Active Choice Plan 500 1500 Deductible*
- ☐ Custom plan (attach custom menu)

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

Blue Shield Dental plans

30 **Blue Shield Dental plans**

☐ Single dental plan option

☐ Dual choice dental plan options
- 1 PPO + 1 HMO
- 2 HMOs
- 1 HMO + 1 INO

☐ Triple choice dental plan options:
- 1 PPO
- 3 HMOs
- 2 HMOs + 1 INO
- 2 HMOs + 1 PPO

Dental HMO			**Dental HMO Voluntary**
☐ DHMO Basic	☐ DHMO Plus	☐ DHMO Deluxe	☐ DHMO Voluntary

Dental PPO

☐ Smile℠ Spectrum 50/1500/No Ortho/MAC	☐ Smile℠ Spectrum Premier 50/1500/No Ortho/MAC
☐ Smile℠ Spectrum 50/1500/Ortho/MAC	☐ Smile℠ Spectrum Premier 50/1500/Ortho/MAC
☐ Smile℠ Spectrum 50/1500/Ortho/U90	☐ Smile℠ Spectrum Premier 50/2000/No Ortho/MAC
☐ Smile℠ Spectrum Premier Plus 50/1500/Ortho/U90	☐ Smile℠ Spectrum Premier 50/2000/Ortho/MAC
☐ Smile℠ Spectrum Premier Plus 50/1500/No Ortho/U90	☐ Smile℠ Spectrum Premier 50/2000/No Ortho/U90
☐ Smile℠ Spectrum Premier 50/1500/No Ortho/U90	☐ Smile℠ Spectrum Premier 50/2000/Ortho/U90
☐ Smile℠ Spectrum Premier 50/1500/Ortho/U90	☐ Smile℠ Basic 75/1000/No Ortho/MAC

Dental PPO Voluntary

☐ Smile℠ Basic Voluntary 75/1000/No Ortho/MAC

Section B (C17607) – Blue Shield Life Dental plans*

Dental INO

☐ Smile℠ In-Network Only Dental Voluntary Plan 50/1500/ Endo-Perio 50%/Ortho	☐ Smile℠ In-Network Only Dental Voluntary Plan 50/2500/ Endo-Perio 50%/Ortho
☐ Smile℠ In-Network Only Dental Voluntary Plan 50/1500/ Endo-Perio 50%/No Ortho	☐ Smile℠ In-Network Only Dental Voluntary Plan 50/2500/ Endo-Perio 50%/No Ortho

Dental INO Voluntary

☐ Smile℠ In-Network Only Dental Plan 50/1500/Endo-Perio 80%/Ortho	☐ Smile℠ In-Network Only Dental Plan 50/2500/Endo-Perio 80%/Ortho
☐ Smile℠ In-Network Only Dental Plan 50/1500/Endo-Perio 80%/No Ortho	☐ Smile℠ In-Network Only Dental Plan 50/2500/Endo-Perio 80%/No Ortho

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Section C (C17607) – Blue Shield Life Vision plans*

☐ Vision Standard15/25/120	☐ Vision Plus with Contacts 15/25/150/120
☐ Vision Standard 15/25/130	☐ Vision Plus 0/0/120
☐ Vision Standard 15/25/150	☐ Vision Plus 0/0/130
☐ Vision Standard with Contacts 15/25/150/120	☐ Vision Plus 0/0/150
☐ Vision Standard 0/25/130	☐ Vision Plus with Contacts 0/0/150/120
☐ Vision Standard 0/0/120	☐ Vision Plus 0/25/130
☐ Vision Standard 0/0/130	☐ Vision Deluxe 15/25/120
☐ Vision Standard 0/0/150	☐ Vision Deluxe 15/25/130
☐ Vision Standard with Contacts 0/0/150/120	☐ Vision Deluxe 15/25/150
☐ Eye Exam Only	☐ Vision Deluxe with Contacts 15/25/150/120
☐ Vision Standard Materials Only -/25/100	☐ Vision Deluxe 0/25/130
☐ Vision Standard Materials Only -/15/120	☐ Vision Deluxe 0/0/120
☐ Vision Plus 15/25/120	☐ Vision Deluxe 0/0/130
☐ Vision Plus 15/25/130	☐ Vision Deluxe 0/0/150
☐ Vision Plus 15/25/150	☐ Vision Deluxe with Contacts 0/0/150/120

Vision Voluntary†

☐ Vision Standard Voluntary 15/25/120	☐ Vision Deluxe Voluntary 15/25/150
☐ Vision Plus Voluntary 15/25/120	

☐ Other Vision (specify) _____

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

Section D (C17607) – Basic Group Term Life/AD&D Insurance and Supplemental Life and AD&D Benefits*

Eligibility (check one): ☐ All full-time employees
☐ Only those employees enrolled in the Blue Shield/Blue Shield Life medical plan

Employee life/AD&D insurance:

☐ Flat $ _____

☐ Multiple of salary _____ times salary, maximum $ _____

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

☐ Graded: 1. Class description _____flat amount $ _____.
2. Class description _____ flat amount $ _____.
3. Class description _____ flat amount $ _____.
4. Class description _____ flat amount $ _____.

☐ Dependent life insurance: $ _____ (between $1,000 and $5,000 in $1,000 increments).

The dependent coverage amount listed is per dependent, and coverage is only available for employees who also elect life/AD&D insurance. Dependent benefit may not be more than 50% of the employee's benefit. Benefits for children ages 14 days to 6 months is 10% of dependent benefit.

Indicate life insurance contribution amount here:

For employees _____ % For dependents _____ %

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

Group supplemental life and supplemental AD&D insurance*: To be eligible for supplemental life or supplemental AD&D coverage, the individual must be enrolled in basic group term life. Coverage is subject to participation levels and Evidence of Insurability.

Employee supplemental life and Supplemental AD&D insurance (check all that apply):

☐ Supplemental life insurance ☐ Supplemental AD&D insurance

Eligible class(es)_____ ☐ "All Eligible Employees" or ☐ Other_____

☐ Increments of $_____ ☐ Multiple(s) of salary:_____times salary,

Maximum of $ _____ Guaranteed issue of $ _____

Spouse/domestic partner supplemental life insurance. Only available if employee also elects supplemental life insurance and cannot exceed 50% of the employee benefit amount. (Check all that apply)

☐ Supplemental life insurance ☐ Supplemental AD&D insurance

Increments of $_____ Maximum of $ _____ Guaranteed issue of $ _____

Dependent child(ren) supplemental life insurance. Only available if employee also purchases supplemental life insurance and cannot exceed 50% of employee benefit amount.

Increments of $5,000 to a maximum of $10,000

Is this a replacement of similar coverage? ☐ Yes ☐ No. (If yes, a copy of prior carrier's plan/policy is required for claims administration.)

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

31 **Blue Shield 65 Plus plans** ☐ Custom plan (attach custom menu)

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

1 Access+ HMO SaveNet products are only available alongside our Access+ HMO products in designated Southern California counties: Kern, Marin, Orange, Sacramento, San Francisco, San Luis Obispo, San Mateo, Santa Clara, Santa Cruz, Sonoma, Stanislaus, Ventura, Yolo and portions of Contra Costa, Los Angeles, Riverside, San Bernardino, and San Diego.

2 These high-deductible health plans are HSA-compatible.

3 Local Access+ HMO products are only available in designated counties: Marin, Orange, San Francisco, San Luis Obispo, Santa Clara, Santa Cruz, Sonoma, Stanislaus, and Yolo, and portions of Contra Costa, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Mateo and Ventura.

4 ABHP – HRA – Rx is not part of the medical plan.

5 ABHP – HSA or HRA (deductible applies to out-of-pocket max, Rx is part of the medical plan).

6 Includes pediatric vision benefits to age 19.

32 **Blue Shield of California Optional benefits selection**

- Cannot be purchased without a medical plan.
- For Dual Choice packages, the same optional benefits must be purchased for all the plans selected.
- The rider product type must match the medical plan product type – only HMO to HMO etc.
- Hearing aid rider is not available with PSP plans, but it available with POS

☐ Infertility rider Select plan option(s): ☐ HMO ☐ PPO ☐ POS ☐ PSP	☐ Access+ HMO and/or POS chiropractic rider ☐ Access+ HMO and/or POS chiropractic/acupuncture rider ☐ Hearing-aid rider Select plan option(s): ☐ HMO ☐ PPO ☐ Other _____

Blue Shield of California outpatient prescription drug plan options (available for PPO plans)

33 Choose one calendar-year brand-name deductible option below:

☐ $0 per person ☐ $150 per person ☐ $250 per person ☐ $500 per person

Choose one of the Rx drug plan options below:*

☐ PPO $0 (generic formulary)/$20 (brand-name formulary)/ $40 (brand-name non-formulary) Rx drug plan	☐ PPO $10/$25/$40 Rx drug plan
☐ PPO $3/$20/$40 Rx drug plan	☐ PPO $10/$30/$50 Rx drug plan
☐ PPO $5/$10/$25 Rx drug plan	☐ PPO $10/$30/ 50% $45 min $100 max Rx drug plan
☐ PPO $5/$40/ 50% $50 min $100 max Rx drug plan	☐ PPO $15/$30/$45 Rx drug plan
☐ PPO $10/$15/$30 Rx drug plan	☐ PPO $15/$30/ 50% $45 min $100 max Rx drug plan
☐ PPO $10/$20/$35 Rx drug plan	☐ PPO $0 (value-based tier drugs)/$10 (generic formulary)/ $25 (brand- name formulary)/$40 (brand-name non-formulary) Rx drug plan

* Specialty Drugs 30% up to a $200 maximum.

Blue Shield of California outpatient prescription drug plan options (available for HMO/POS)

34 Choose one calendar-year brand-name deductible option below:

☐ $0 per person ☐ $150 per person ☐ $250 per person

Choose one of the two-tier Rx drug plan (closed formulary) options below:†

☐ HMO/POS $5 (generic formulary)/$10 (brand-name formulary) Rx drug plan	☐ HMO/POS $10/$20 Rx drug plan
☐ HMO/POS $5/$15 Rx drug plan	☐ HMO/POS $10/$25 Rx drug plan
☐ HMO/POS $10/$15 Rx drug plan	☐ HMO/POS $15/$25 Rx drug plan
	☐ HMO/POS $15/$30 Rx drug plan

Choose one of the three-tier Rx drug plan (closed formulary) options below:†

☐ HMO/POS $0 (generic formulary)/$20 (brand-name formulary)/$40 (brand-name non-formulary) Rx drug plan	☐ HMO/POS $10/$25/$40 Rx drug plan
☐ HMO/POS $3/$20/$40 Rx drug plan	☐ HMO/POS $10/$30/$50 Rx drug plan
☐ HMO/POS $5/$10/$25 Rx drug plan	☐ HMO/POS $10/$30/ 50% $45 min $100 max Rx drug plan
☐ $5/$40/50% $50 min $100 max Rx drug plan	☐ HMO/POS $15/$30/$45 Rx drug plan
☐ HMO/POS $10/$15/$30 Rx drug plan	☐ HMO/POS $15/$30/ 50% $45 min $100 max Rx drug plan
☐ HMO/POS $10/$20/$35 Rx drug plan	☐ HMO/POS $0 (value-based tier drugs)/$10 (generic formulary)/$25 (brand- name formulary)/$40 (brand-name non-formulary) Rx drug plan

† Specialty Drugs 30% up to a $200 maximum.

Employer Distribution of member *Evidence of Coverage/Certificate of Insurance* (EOC/COI) booklet requirements

35

For groups of 51 to 1,999 eligible employees

You are responsible for the distribution of the EOC/COI booklets to your covered employees.

Electronic versions will be distributed via the Blue Shield employer website. Blue Shield will notify the individual responsible for EOC/COI distribution, identified in Section 5 above, by email when the EOC/COI is ready for distribution. Employer is responsible for distributing these documents using one of the following methods; (1) posting on the company intranet for employee access, (2) emailing these documents directly to their employees, or (3) providing employees with instructions from Blue Shield about how to electronically retrieve the documents from the Blue Shield website. Printed versions will only be mailed to the employer directly upon request. Employers requesting printed copies will receive up to 10% of the total subscriber count at no additional cost to distribute to employees.

Please note: Electronic distribution will not apply to life insurance certificates. Printed versions of life insurance certificates will be mailed directly to employees.

☐ I elect to receive printed, not electronic, EOC/COI booklets. I understand that I am responsible for distributing the documents to my covered employees and understand that the dues/premiums charged for the coverage will include cost to print the documents.

For groups of 2,000 or more eligible employees

Please note: Available only for custom groups, or groups who enroll in vision benefits, or group term life and AD&D insurance benefits without a medical plan.

☐ Electronic format only: Documents will be distributed to the employer via CD-ROM or Blue Shield web site. Employer is responsible for posting these documents on the company intranet for employee access.

☐ Electronic and printed format: Electronic versions will be distributed via CD-ROM or Blue Shield web site. Employer is responsible for posting these documents on the company intranet for employee access. Printed versions will be mailed to the employer directly. Employers will receive 10% of the total subscriber count to distribute to employees.

☐ Printed format only: Printed versions will be mailed to the employer directly. Employers will receive the total subscriber count to distribute to employees.

Note: You can log in to bscadocs.com and download a Summary of Benefits & Coverage (SBC) for each plan you are considering. Once you purchase a plan(s), you will be asked to complete an attestation confirming you have downloaded the SBC(s) for those plans and will issue them to enrollees and prospective enrollees as required by law.

Payment (deposit check amount – this amount will be applied to the first month's premium)

36

The group herewith tenders the amount of $ _____ and, in consideration of approval of the application it will make and in event of such approval, promises to pay this company as appropriate any balance necessary to constitute the full initial payment for the group benefits herein identified on this form. It is understood that coverage will not commence until the application has been approved and the conditions of coverage are accepted by the employer.

Please note that depositing the group's check does not constitute approval of the group's application. Blue Shield of California will refund the full deposit to the group if the group application is declined.

Detail of how deposit check amount should be applied:

$ _____ applied to medical

$ _____ applied to dental PPO

$ _____ applied to dental HMO

$ _____ applied to dental INO

$ _____ applied to vision

$ _____ applied to life insurance

$ _____ other, please indicate:

_____

Agreement

37 The group hereby applies for the group products selected on this application, as those benefit plans are outlined in the benefit summary(ies), with the understanding and agreement that:

1. Group benefits will not become effective, unless:
   a. Blue Shield receives and approves the application; and
   b. The group meets Blue Shield's underwriting requirements, including minimum participation and contribution requirements.
2. The group agrees to pay the required monthly premium/dues to Blue Shield in a timely manner.
3. The group agrees to:
   a. Enroll all employees as they become eligible, if the Health Service Contract/Group Policy is issued on a non-contributory basis; or
   b. Give all eligible employees an opportunity to apply for such group benefits, if the Health Service Contract/Group Policy is issued on a contributory basis.
4. No waiver or requested change in coverage will become effective unless agreed to and signed by an officer of Blue Shield.
5. For life insurance/AD&D products only: enrolling employees must be actively at work or meet the active employment provisions for coverage before coverage may become effective. Coverage for any person not meeting these provisions on the effective date of the Health Service Contract/Group Policy, or any increase in coverage for any person not meeting these provisions on the effective date of such increase in coverage, will be deferred until the person returns to work or active employment.
6. The group consents to and authorizes Blue Shield to send all business correspondence through electronic communications. Blue Shield will notify the group contact, identified in Section 5 above, by email. Other forms of contact will only be made upon direct request. Employers requesting mail correspondence may incur an additional cost.

☐ Check here if the group is opting out of receiving electronic communications from Blue Shield. It is understood that if the group opts out of electronic communications, a charge for this additional cost will be reflected in the premium.
☐ phone ☐ fax ☐ mail

Authorization and Signature

38 The following authorization section must be signed by the primary group representative/contact.

This is an application for coverage. The group understands that no contract for coverage will exist until Blue Shield has completed its review and communicated to the applicant or the applicant's producer that the application has been accepted and a group health service contract has been issued. The group representative certifies, to the best of his or her knowledge and belief, all of the responses provided in this application are true, correct, and complete. The group understands that if it has committed fraud or made an intentional misrepresentation of any material fact in conjunction with this application within the first 24 months of coverage, Blue Shield of California may pursue one of the following remedies: coverage may be cancelled, or the applicable premium/dues may be adjusted, or following notice, the Health Service Contract/Group Policy may be rescinded.

Authorized group representative signature	Name and title (please print)	Date

Producer information (to be completed by producer or general agent)

39				
	Producer name		Phone number	Fax Number
	Producer address (P.O. box not acceptable)			
	City		State	ZIP code
	Producer email		Producer tax ID number (commissions will be reported under this number)	
	General agent tax ID number		Department of Insurance license number	
	General agent name		General agent email	
	Region		Code number	
	Today's date (required)	Producer signature (required)		Print name
	I certify to the best of my knowledge and belief that all responses given above are true and correct and complete.			

Blue Shield account/ sales executive	Phone number	Fax number	Office number
Sales representative number and region		Account manager/sales analyst (if applicable)	