Anthem BlueCross

Health · Pharmacy · Dental · Vision · Life · Disability

California | 2018

Group administrator manual

Small Group employers

For groups with 1-100 employees

The entire terms are contained in the respective contract documents (the Combined Evidence of Coverage, applicable certificate, policy and/or employer application) for each line of coverage. In the event of a conflict between this manual and the plan and/or policy under which the group insurance coverage is provided, the terms of the plan and/or policy will prevail. The guidelines in this manual are subject to change from time to time without prior notice.

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Thank you for choosing Anthem

Welcome to Anthem. We've created this *Group Administrator Manual* to help you find quick answers about enrollment, billing, membership changes and other day-to-day administrative tasks. But we're also available to speak with you one-on-one to answer your questions and help make your day easier! You can always get more help by logging in at anthem.com/ca or calling your Customer Service team at 1-855-854-1429.

We know choosing the right plan for your employees and their families is an important decision. That's why we're here to make sure you get all the help you need to manage your company's health plan.

We'll be working with you to make sure you have:

- Someone to help you and your employees navigate important life events
- A clear understanding of the rules and regulations regarding health care
- Access to your profile and benefits on anthem.com/ca
- What you need to start using EmployerAccess – our secure employer portal – where you can manage your group's enrollment, premium payments and other important company information

We want to make sure that you have access to programs, tools and resources that can help you get the information you need, when you need it. Our mission is to improve the lives of the people we serve and the health of our communities. Let's work together to make sure you and your employees can be as healthy as possible and lower health care costs every step of the way.

Register now

To register for EmployerAccess through anthem.com/ca:

1. Visit anthem.com/ca and select **Employers** from the Menu tab.
2. Select the **Register Now** link and follow the prompts to finish. (You'll need your group/case number to complete the process.)

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Questions about...	Contact	Phone/Fax/Email/Web	Address	Hours of operations (all hours are M-F, unless otherwise stated)
Billing	Enrollment and Billing	Phone: 1-855-854-1429 Fax: 1-855-750-2227 Email: small.group@anthem.com Web: EmployerAccess	Anthem Blue Cross P.O. Box 51011 Los Angeles, CA 90051-5311	8 a.m. - 6 p.m. PT
Enrollment	Enrollment and Billing	Phone: 1-855-854-1429 Fax: 1-855-750-2227 Email: small.group@anthem.com Web: EmployerAccess	Anthem Blue Cross Small Group Services P.O. Box 9062 Oxnard, CA 93031-9062	8 a.m. - 6 p.m. PT
Cal-COBRA and/or COBRA	Enrollment and Billing	Phone: 1-855-854-1429 Fax: 1-855-750-2227 Email: small.group@anthem.com Web: EmployerAccess	n/a	8 a.m. - 6 p.m. PT
Member Services	Claims	Phone: 1-855-383-7248	Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007	7 a.m. - 7 p.m. PT
Dental claims	Dental Services	Phone: 1-888-209-7852	Dental Services P.O. Box 9066 Oxnard, CA 93031-9066	8 a.m. – 5 pm. PT (live person) 24/7 self-service interactive voice response (IVR)
Dental claims	Dental Prime and Complete Customer Service	Phone:1-877-567-1804	Anthem Dental Claims P.O. Box 1115 Minneapolis, MN 55440-1115	5 a.m. – 5 p.m. PT
Vision claims	Blue View Vision℠ Customer Service	Phone: 1-866-723-0515	Blue View Vision Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111	Mon. - Sat., 7:30 a.m. - 11 p.m. PT Sun., 11 a.m. - 8 p.m. PT
Life claims	Life Claims	Phone: 1-800-552-2137	Life Claims Service Center P.O. Box 105448 Atlanta, GA 30348-5448	5 a.m. - 5 p.m. PT
Pharmacy (retail)	Express Scripts®	Phone: 1-866-297-1013	Express Scripts ATTN: Commercial Claims P.O. Box 2872 Clinton, IA 52733-2872	24 hours a day, seven days a week
Pharmacy (home delivery)	Express Scripts	Phone: 1-888-452-4357 TTY: 1-866-297-1013 Web: express-scripts.com	Express Scripts Home Delivery Service P.O. Box 66558 Saint Louis, MO 63166-6588	24 hours a day, seven days a week
Coverage while traveling (out-of-state providers)	BlueCard program	Phone: 1-800-810-2583 Web: bcbs.com	n/a	24 hours a day, seven days a week

Questions about...	Contact	Phone/Fax/Email/Web	Address	Hours of operations (all hours are M-F, unless otherwise stated)
Section 125 Premium Only Plan (POP)	WageWorks	Phone: 1-800-876-7548 Web: wageworks.com	n/a	8 a.m. - 5 p.m. CT
Groups requesting reinstatements	Accounts receivable	Phone:1-888-686-9807	n/a	8 a.m. - 4:30 p.m. PT
Forms and supplies		Web: anthem.com/ca		

You can also access your account 24/7 at EmployerAccess and/or reach us at small.group@anthem.com.

Get instant help with our self-service options

With EmployerAccess, you have password-protected access to real-time information that makes it easy to manage your Anthem account. Our online registration is quick, easy and secure.

Log in to your account to stay up-to-date with the latest information and get access to:

Online enrollment

- Enroll new hires
- Manage open enrollment benefits
- Handle membership information maintenance
- Change employee information (such as address or phone number)
- Terminate an employee's and/or their dependent's benefits
- Reinstate employee benefits
- Add dependents to an employee's benefits coverage
- View contract and coverage information (for example, current address, phone number, plan details)
- View employee coverage history from previous years
- Request member ID cards
- Find a Doctor tool to help employees locate a doctor, hospital or other health care provider

Online billing

- Receive bills and send payments
- Know when checks will clear so you have control over cashflow
- Review, download and print account statements at your convenience – no waiting for the mail
- Have fraud prevention – no checks get lost
- View, print and download bills
- Pay bills electronically
- Schedule recurring payments
- Manage bank accounts with privacy
- Manage billing email (receive billing notifications)

Other information

- View and download activity reports for transactions processed through EmployerAccess
- View and download your company's benefit plans

Want to learn more about EmployerAccess? Give us a call at ***1-855-854-1429*** and find out how it can help you make managing your account easier and faster.

Submitting electronic eligibility transactions with Anthem

You can submit electronic enrollment using EmployerAccess, the Census Enrollment tool, Electronic File (834), and real time. Anthem encourages the use of online enrollment for vendors, brokers, and general agencies to process and submit employee benefit elections and maintenance information.

Benefits of electronic enrollment:

- Reduce paperwork
- Increased availability of Member services
- Make changes and enrollments quickly
- Create an audit trail of all changes
- Greater data accuracy
- Improved accuracy of monthly premium statements

Sending eligibility electronically can be used for both initial enrollment and ongoing maintenance. For an initial enrollment, a complete roster of employees with their dependents and their selected coverage may be required. If you're interested in starting electronic enrollment, contact your agent and/or Enrollment and Billing. See *Electronic enrollment and eligibility data submission guidelines* for more information.

Materials and other documents

Our Small Group Easy Renew website has applications, forms, rates, brochures and other materials you may need. You can also use Easy Renew all year round to access items you need to manage and maintain your business with us. Simply go to anthem.com/easyrenew. You can also access Easy Renew from EmployerAccess by choosing the Forms tab.

Interactive Voice Response system

Our Interactive Voice Response (IVR) system uses voice response software to guide callers to the information they need. Touch-tone response and live agents are also available.

To get started, have your employer group number available and call 1-855-854-1429. You'll be prompted to say or enter your information. Then, simply press 1 to get your group administrator options.

Welcome to Anthem Blue Cross Small Group Services department

Prompt	Response
Are you a... - Group administrator? - Broker? - Sales agent? - Member?	Press 1 or say 'Group administrator'
Was the group coverage elected through an exchange?	No.
Are you calling... - Billing? - Making a payment by phone? - EmployerAccess or something else?	No self-service options

Understanding your group(s)

New groups will now be provided three types of numbers associated with their coverage. They are:

- **Case number:** This number identifies the company information. This will be the number you will use when logging into EmployerAccess. Anthem will use the case number on your communications. For example, your renewal packet.
- **Bill entity number(s):** This number references the bill associated with a case number. For example, a case number may have two bill entities associated with it – one for the active subscribers enrolled on the case and one for Cal-COBRA members.
- **Group suffix(es):** This number will be provided to identify the plan(s) associated with the case number. For example, if you elect three medical plans, one dental and one vision plan; then the case number will have five group suffixes created.

  The suffixes will be on the ID card listed as the Group No. and can start with either J or M.

Group requirements

Supplying correct information

For Anthem to effectively administer your group's benefits, you must submit timely, accurate information related to eligibility changes. This includes:

- New employee or dependent additions
- Changes in plans
- Changes in terminations
- Address changes
- Leaves of absence
- COBRA and Cal-COBRA notices
- Medicare eligibility and individuals turning age 65

You also must notify Anthem about changes that affect the group. These changes include, but are not limited to:

- Address change for the company
- Change of company waiting period
- Change in company ownership
- Change in group administrator
- An acquisition or merger of or by another company or business entity
- A change in the number of people employed by the company when such a change may affect the group's COBRA, Cal-COBRA or Medicare payee status.

Important note: Failure to supply Anthem with updated eligibility information may delay coverage or cause premium inaccuracies that your group or your employees may not be able to recover.

Determining group size

For plan years commencing on or after January 1, 2016 (new and renewing), a small employer is defined as an employer employing an average of at least one, but no more than 100 full-time employees, including full-time equivalent, employees during the preceding calendar year and who employs at least one employee on the first day of the plan year. For purposes of determining employer eligibility in the small employer market, California adopted the federal method for counting full-time employees and full-time equivalent employees.[1]

The information reflected in this document is intended only as general guidance to assist you in determining your group's size under the Affordable Care Act and California Senate Bill 125, starting in 2016. It is not intended as legal or financial advice or opinion. For specific guidance concerning the Affordable Care Act, the Internal Revenue Code or California State laws or regulations, you should consult with your attorney, Certified Public Accountant or other authorized consultant or advisor. The contents of this document should not be construed as or relied upon for legal or tax advice.

Who is an employee?

The term "employee" means an individual who is an employee under the common law standard,[2] which largely rests on the amount of control the employer has over the employee.

- A leased employee,[3] sole proprietor, partner in a partnership, 2% S corporation shareholder, or a worker described in section 3508[4] is not an employee for the purpose of determining group size.

Full-time and full-time equivalent (FTE) employees

Full-time employee: A full-time employee means, with respect to a calendar month, an employee who is employed an average of at least 30 hours of service per week (or 130 hours of service in a calendar month) with an employer.

Full-time equivalent employee: A full-time equivalent employee (FTE) is a combination of employees, each of whom individually is not a full-time employee because he or she is not employed on average at least 30 hours of service per week with an employer, but who in combination, are counted as the equivalent of a full-time employee.

The number of FTEs for each calendar month in the preceding calendar year is determined by calculating the aggregate number of hours of service for that calendar month for employees who were not full-time employees (but not more than 120 hours of service for any employee) and dividing that number by 120. The resulting number is the number of FTEs on a monthly basis.

1 California Senate Bill 125 (2015).

2 26 C.F.R. § 31.3401(c)-1(b).

3 As defined in 26 U.S.C. § 414(n)(2)

4 Described in 26 U.S.C. § 3508.

The information in this document is intended only as general guidance to assist you in determining your group's size under the Affordable Care Act (ACA) and California Senate Bill 125 (2015), starting in 2016. It is not intended as legal or financial advice or opinion. People seeking specific guidance concerning the ACA, the Internal Revenue Code or California State laws or regulations should consult with their attorneys, certified public accountants or other authorized consultants or advisors. These contents should not be construed as or relied upon for legal or tax advice in any particular circumstance or factual situation.

Additional information

- All paid time off must be counted as hours of service in determining the number of hours worked.
- Employers must use one of three methods to calculate hours of service for non-hourly employees:
  1. Actual hours of service; or
  2. Days-worked equivalency method: An employee is credited with eight hours of service for each day for which the employee would be required to be credited with at least one hour of service; or
  3. Weeks-worked equivalency method: An employee is credited with 40 hours of service for each week for which the employee would be required to be credited with at least one hour of service.
- In general, seasonal employees are not treated any differently than other employees. They are counted as full-time or part-time, depending on the number of hours they work.
- However, if the sum of an employer's full-time and FTE employees exceeds 100 for 120 days or less during the preceding calendar year, and the employees in excess of 100 who were employed during that period of no more than 120 days are seasonal workers, then the employer is not an applicable large employer for the current calendar year.

Aggregation rules

All employers treated as a single employer under section 414(b), (c), (m), or (o) of the Internal Revenue Code are treated as a single employer for purposes of determining group size. Therefore, all employees of a controlled group of entities under section 414(b) or (c), an affiliated service group under section 414(m), or an entity in an arrangement described under section 414(o), are taken into account in determining whether the members of the controlled group or affiliated service group together are an applicable large employer.

Determining appropriate aggregation is a very fact-specific analysis. You should consult your own attorney, certified public accountant or other authorized consultant or advisor in determining whether and how the aggregation rules apply to you.

Note: The information provided is to help you determine your group's size using the same calculation to determine employer liability under the "Shared Responsibility for Employer" provisions of the ACA and the Internal Revenue Code. Pursuant to the ACA, California has adopted the federal definition of who is an employee for purposes of determining your group's correct market segment (for example, Large Group or Small Group).

Employee participation requirements

A certain percentage of employees must enroll in the Anthem coverage offered by the employer.

To calculate employee participation:

1. Start with the total number of eligible employees, including the company's owner(s).

2. Subtract the number of employees with allowable waivers, For example:

- Employees with Medicare, Medi-Cal or military coverage.
- Those covered as a dependent on a spouse's or parent's employer-sponsored group plan.
- Those who have their own individual coverage either on or off the exchange.

The result indicates the total number of eligible employees.

3. Then, subtract the number of employees who simply choose not to participate. Now, you have the total number of eligible enrolling employees.

4. Finally, divide the number of eligible enrolling employees by the number of eligible employees. The resulting percentage indicates the group's participation.

Example 1 – Group meeting participation:

Total number of employees:	10
Allowable waivers (1 Medi-Cal, 1 military, 2 Medicare):	-4
Total number of eligible enrolled employees:	6

Total eligible enrolling employees	Number of eligible employees	Total participation
6	6	100%

Example 2 – Group NOT meeting participation:

Total number of employees:	10
Invalid waivers (4 do not want coverage):	-4
Total number of eligible enrolled employees:	6

Total eligible enrolling employees	Number of eligible employees	Total participation
6	10	60%

Product participation requirements

Medical participation requirements for 1-100

A Small Group must have at least one eligible employee. A sole proprietorship, partnership or qualified joint venture (such as, a husband and wife or domestic partners acting as co-owners of the business and filing taxes as a qualified joint venture) must have a common-law employee to qualify for enrollment. An owner/spouse/domestic partner does not constitute a common-law employee.

Examples of groups that are not considered small employers:

- Groups wholly owned by an individual and/or a spouse and/or domestic partner-employee
- Carve-out groups
- Employer groups with less than 51% of employees working in California

Group participation requirements:

- 70% participation for groups with 1-14 eligible employees.
- 50% participation for groups with 15 or more eligible employees.
- The minimum participation is 100%, if noncontributory.

For new groups enrolling during the annual open enrollment period, November 15 to December 15, participation requirements will not be enforced. The effective date will be January 1 of the following year.

Dental Participation for 2-100

You may offer one Dental Net DHMO plan and one Dental Complete PPO plan.

Dental Net DHMO plan participation:

Available for 2–100 employee Small Groups, a minimum of 2 employees must enroll.

Group participation requirements:

- 70% participation for groups with 2-14 eligible employees.
- 50% participation for groups with 15 or more eligible employees.
- The minimum participation is 100%, if noncontributory.
- Dual Option (employer can select 2 plans to offer to employees) is available for groups with at least 10 eligible employees (A minimum of 2 employees must enroll in each of the two options and the two plans offered must have a 20% premium differential.)

Dental Complete PPO Classic and Enhanced plans enrollment requirements:

- 2–4 eligible employees groups: 100% of eligible employees not covered by another dental plan (and a minimum of 2 employees) are required to enroll.
- 5–14 eligible employees: A minimum of 70% of employees not covered by another dental plan are required to enroll. A minimum of 2 employees must enroll.
- 15+ eligible employees: A minimum of 50% of employees not covered by another dental plan are required to enroll. A minimum of 2 employees must enroll.
- Dual Option (employer can select two plans to offer to employees) is available for groups with at least 10 eligible employees. (A minimum of 2 employees must enroll in each of the two options and the two plans offered must have a 20% premium differential.)

Voluntary dental plans are offered to groups of 5-100 enrollment requirements:

- A minimum of 5 employees must enroll (there is no participation-percentage requirement for our voluntary plans).
- Dual Option (employer can select two plans to offer to employees) is available; a minimum of 5 employees must enroll in each plan. (You may choose one voluntary Dental Net DHMO plan and one voluntary Dental Complete PPO plan.)

Vision participation for 2-100

Employer-sponsored:

- 70% participation for groups with 2-14 eligible employees
- 50% participation for groups with 15 or more eligible employees
- The minimum participation is 100% if noncontributory
- A minimum of 2 employees must enroll
- Dual Option (employer can select two plans to offer to employees) is available. (You may choose a maximum of two plans, but you may not pair a voluntary plan with an employer-sponsored plan.)

Voluntary vision:

- Voluntary vision plans available for 5–100 employee Small Groups. Must have a minimum of 5 subscribers enroll.
- Dual Option (employer can select two plans to offer to employees) is available. You may choose a maximum of two plans but you may not pair a voluntary plan with an employer sponsored plan.)
- Voluntary vision is available as a stand-alone product or in conjunction with medical, dental and/or life.

Life and Disability participation enrollment requirements

Basic Life & Accidental Death & Dismemberment, Short Term Disability or Long Term Disability:

- A minimum of 2 employees must enroll
- 75% participation
- 100% participation for noncontributory plans

Basic Dependent Life:

- A minimum of 2 employees must enroll
- 100% participation for noncontributory plans
- Dependent coverage cannot exceed 50% of the employee amount

Optional/Voluntary Life/Accidental Death & Dismemberment:

- Available for groups of 10 or more eligible employees
- The greater of 20% or 5 eligible employees must enroll

Voluntary Short Term Disability and Voluntary Long Term Disability:

- Available for groups of 10 or more eligible employees
- The greater of 20% or 10 eligible employees must enroll

You must keep the corresponding minimum participation levels in order to stay eligible. You are subject to cancellation or nonrenewal if participation falls below the required minimum, and Anthem may conduct periodic audits to confirm participation levels.

For purposes of calculating participation, the following may be considered as valid waivers, subject to receipt of a declination and proof of other coverage:

- Employer-sponsored group coverage through another employer
- Individual coverage purchased on or off the exchange
- Medi-Cal
- Medicare
- United States military coverage

An owner of multiple entities will not be considered a valid waiver if the owner is declining due to coverage under another entity in which he/she holds ownership.

If a husband and wife/domestic partner both work for the same employer, they may apply separately as employees, or one may be a dependent on the other's coverage. Husband and wife/domestic partner groups are not eligible without a W-2 eligible employee. The children may apply as dependents of either employee. Dependents cannot be on both parents' policies under the same group.

Special provisions:

- If your group pays 100% of the employees' health, dental, vision and/or life premiums, then 100% of the eligible employees must participate.

Employer contribution requirements

You may choose your preferred approach for contributing to employee health premiums. Payroll deduction is required, if contributory.

You have the following contribution options:

Medical

1. **Traditional option** — A minimum contribution of 50% of each covered employee's monthly health premium.
2. **Fixed-dollar option** — Any fixed-dollar amount of $100 or greater (in $5 increments) of each covered employee's health premium.
3. **Percentage and plan option** — A minimum of 50% toward a specific plan, chosen by you.

During the annual open enrollment period, November 15 to December 15, medical contribution requirements will not be enforced.

Employer waiting periods

Pursuant to SB 1034 (2014), Anthem will not impose a waiting period. Groups are responsible for providing Anthem accurate member eligibility dates, taking into account any group-imposed waiting period. In accordance with SB 1034, groups are responsible for ensuring that any group-imposed waiting period is consistent with Section 2708 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-7).

The following are the waiting period options:

- First of the month following date of hire
- First of the month following one month from date of hire
- First of the month following two months from the date of hire, not to exceed 90 days[1]

You have the option to waive the waiting period for all new hires at the initial group enrollment only.

You may only choose one waiting period for your employees; dual waiting periods are not allowed.

Your group's waiting period is applied to all employees in the group, with no exceptions for any eligible employee.

1 If it exceeds 90 days, the effective date will be first of the month following one month from the date of hire.

Benefit modifications

The required documentation must be complete and accurate to process the request. The completed documentation, including all necessary Anthem forms, must be received by Anthem within 30 days of the requested effective date. **Non anniversary** benefit modifications will not be accepted. Please refer to the *Benefit modification job aid* for more information about when you can request certain types of benefit modifications and what documents are required when you submit your request.

Important note: 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.

Subscriber changes

Covered subscribers may move to a different plan and/or product offered by their group at the anniversary month or with a qualifying event. This can be done by submitting a letter from the group on company letterhead explaining the request to change or by completing the Plan Change Request form on the anniversary date.

There are specific times when groups can submit requests for making certain types of benefit modifications, including requests for modifications that can only be made on the group's anniversary date. Please refer to the *Benefit modification job aid* below for more information about when you can request certain types of benefit modifications and what documents are required when you submit your request.

Benefit modification job aid

Benefit modification	When eligible	Documents necessary
Add or downgrade a medical plan	At a group's anniversary date	1. Letter/email from the group signed by owner/officer or renewal documents, if available 2. *Employee Enrollment Application*s for any new enrollments who are not currently enrolled, or renewal documents, if available
Change anniversary month Change in plans or networks **Note:** Once your group exercises the option to change anniversary date, it cannot be changed again for 12 months.	First of the month following receipt of all signed documentation	1. *Anniversary Month Change* form **Note**: By requesting this change, your group's anniversary month will change. You should consult your tax and legal advisors because this change may have an impact on your group's plan year. Request can only be made once in a 12-month period. New rates and benefits may apply. **New rates and benefits may apply.** If your anniversary date is moving from one calendar year to another as a result of this request, **rates and benefits will change**
Add Dental Net (DHMO) 2-100 (A minimum of 2 employees must enroll.)	First of the month following receipt of all documentation	1. Letter/email from the group signed by owner/officer, including contribution amount, or renewal documents 2. *Employee Enrollment Application*s for any new enrollments who are not currently enrolled, or renewal documents, if available 3. Dental Net (DHMO) office numbers

Benefit modification	When eligible	Documents necessary
Add Dental Complete PPO plans for 2-100 (A minimum of 2 employees must enroll; participation requirements apply.) *Classic and Enhanced plan participation* **2–4 eligible employees:** 100% of eligible employees not covered by another dental plan (and a minimum of two employees) are required to enroll. **5–14 eligible employees:** A minimum of 70% of employees not covered by another dental plan are required to enroll. A minimum of two employees must enroll. Dual Option (employer can select two plans to offer to employees) is available for groups with at least 10 net eligible employees. A minimum of two employees must enroll in each of the two options and the two plans offered must have a 20% premium differential. **15+ eligible employees:** A minimum of 50% of employees not covered by another dental plan are required to enroll. A minimum of two employees must enroll. Dual Option (employer can select two plans to offer to employees) is available for groups with at least 10 net eligible employees. A minimum of two employees must enroll in each of the two options and the two plans offered must have a 20% premium differential. **Medlock (packaged enrollment):** All members enrolled in the Anthem medical plan must enroll in Anthem Complete PPO dental plan. The medical plan billing must be included with new group submission materials. Dental tiering must be identical on the medical and dental plans. Example: Enrollees with single medical coverage must also have single dental coverage; enrollees with family medical coverage must also have identical family dental coverage.	First of the month following receipt of all documentation	1. Letter/email from the group signed by owner/officer 2. New *Employer Application* — SIC code required 3. *Employee Enrollment Applications* for any new enrollments who are not currently enrolled, or renewal documents, if available 4. Copy of Agent quote: https://brokerportal.anthem.com/ehb/web/bkr/acc/login.htm
Add Voluntary Dental Net DHMO 5-100*	First of the month following receipt of all documentation	1. Letter/email from the group signed by owner/officer, including contribution amount, or renewal documents 2. *Employee Applications* for any new enrollments who are not currently enrolled, or renewal documents, if available 3. Dental Net (DHMO) provider office numbers 4. Copy of Agent quote: https://brokerportal.anthem.com/ehb/web/bkr/acc/login.htm 5. SIC code required
Add Voluntary Dental Complete PPO 5-100 A maximum of two plans can be chosen, cannot be paired with an employer-sponsored plan. **Note:** A minimum of five employees must enroll (there is no participation percentage requirement for our voluntary plans with a minimum of five enrollments in each plan). The two plans offered must have a 20% premium differential.	First of the month following receipt of all signed documentation	1. Letter/email from the group signed by owner/officer 2. New *Employer Application* 3. *Employee Enrollment Application*s for any new enrollments who are not currently enrolled, or renewal documents, if available 4. Copy of Agent quote: https://brokerportal.anthem.com/ehb/web/bkr/acc/login.htm 5. SIC code required

* All new employees are required to submit a completed application. Those already enrolled in the plans may utilize the Renewal Change Form.

Benefit modification	When eligible	Documents necessary
Add Employer Vision 2-100 (A minimum of two employees must enroll; participation requirements apply.) A maximum of two plans may be chosen and cannot be paired with a voluntary vision plan. **Note:** Canceled Blue View Vision can only be re-added at anniversary date.	First of the month following receipt of all documentation	1. Letter/email from the group signed by owner/officer, including contribution amount 2. *Employee Enrollment Application*s for any new enrollments who are not currently enrolled, or renewal documents, if available 3. Copy of Agent quote: https://brokerportal.anthem.com/ehb/web/bkr/acc/login.htm 4. SIC code required
Add Voluntary Vision 5-100 (A minimum of five employees must enroll; participation requirements apply.) A maximum of two plans can be chosen; cannot be paired with an employer-sponsored plan. **Note:** Canceled Blue View Vision coverage can only be re-added at anniversary date.	First of the month following receipt of all documentation	1. Letter/email from the group signed by owner/officer 2. *Employee Enrollment Application*s for any new enrollments who are not currently enrolled, or renewal documents, if available 3. SIC code required
Add Employee Life Insurance The following amounts are guaranteed issue (GI): $50,000 for 2-9 enrolled Varies by group - see proposal for 10-100 enrolled Coverage amounts over guaranteed issue are subject to life underwriting approval.	First of the month following receipt of all documentation	1. Letter/email from the group signed by owner/officer 2. New *Employer Application* 3. *Employee Enrollment Applications* for any new enrollments who are not currently enrolled, or renewal documents, if available 4. *Evidence of Insurability* form for any amount over guaranteed issue 5. SIC code required 6. Copy of Agent quote: https://brokerportal.anthem.com/ehb/web/bkr/acc/login.htm
Add Dependent Life coverage **Groups of 2-9:** $10,000 spouse/$5,000 child age 15 days to 26 years $5,000 spouse/$2,500 child age 15 days to 26 years **Groups of 10-100:** $15,000 spouse/$7,500 child age 15 days to 26 years $20,000 spouse/$10,000 child age 15 days to 26 years $10,000 spouse/$5,000 child age 15 days to 26 years $5,000 spouse/$2,500 child age 15 days to 26 years $2,000 spouse/$1,000 child age 15 days to 26 years **Note:** Dependent child coverage is applicable for ages 15 days to 26 years.	First of the month following receipt of all documentation	1. Letter/email from the group signed by owner/officer, including desired dependent life amount and contribution amount 2. New *Employer Application* 3. *Employee Enrollment Applications* for any new enrollments who are not currently enrolled, or renewal documents, if available 4. Copy of Agent quote: https://brokerportal.anthem.com/ehb/web/bkr/acc/login.htm **Note:** Employee must purchase basic term life/AD&D to be eligible for dependent life.

Benefit modification	When eligible	Documents necessary
Add Optional Life coverage Available only to groups with 10 or more employees. (Participation requirements will apply: Greater of 20% of eligible employees or five employees must enroll.) **Add Optional Dependent Life coverage** Available when selecting Optional Life **Add Long Term Disability and Short Term Disability products 10-100** 75% of eligible employees (100% required if noncontributory) **Add Voluntary Life coverage** Available only to groups with 10 or more employees. (Participation requirements will apply: Greater of 20% of eligible employees or five employees must enroll.) **Add Voluntary Short Term Disability coverage** Available only to groups with 10 or more employees. (Participation requirements will apply: Greater of 20% of eligible employees or 10 employees must enroll.) **Add Voluntary Long Term Disability coverage** Available only to groups with 10 or more employees. (Participation requirements will apply: Greater of 20% of eligible employees or 10 employees must enroll.)	First of the month following receipt of all documentation	1. Letter/email from the group signed by owner/officer 2. New Employer *Application* 3. *Employee Enrollment Applications* for any new enrollments who are not currently enrolled 4. *Evidence of Insurability* form 5. Copy of Agent quote: https://brokerportal.anthem.com/ehb/web/bkr/acc/login.htm
Add part-time employee eligibility (Does not apply to Life and Disability coverage.)	First of the month following receipt of all signed documentation	1. Letter/email from the group signed by owner/officer 2. *Employee Enrollment Application(s)*, requesting or declining coverage for all eligible part-time employees 3. New *Employer Application* 4. Current *Quarterly State Tax Withholding Report* reconciled 5. *Attestation* form **Note**: Additional documentation and review may be required.
Change contribution option	Once in a 12-month period, effective first of the month following receipt of documentation	1. Letter/email from group's owner/officer requesting the change
Group demographic changes Name change with same owner and no new enrollments	First of the month following receipt of all documentation	1. Letter/email from group signed by owner/officer requesting the name change 2. Fictitious Business Name Filing (sole proprietorship or partnership), or amended Articles of Incorporation (corporations), or amended Articles of Organization (Limited Liability Corp [LLC]) 3. New *Employer Application* **Note**: Additional documentation and review may be required.

Benefit modification	When eligible	Documents necessary
Name change with new ownership and enrollment changes	First of the month following receipt of all documentation	1. Letter/email from group signed by owner/officer requesting the name change 2. New *Employer Application* 3. *Employee Enrollment Applications* for new owners along with the Eligibility Statement completed in full 4. Purchase Agreement, Federal Tax ID Letter, Fictitious Business Name Filing (sole proprietorship or partnership), or amended Articles of Incorporation (corporations), or amended Articles of Organization (Limited Liability Corp [LLC]) **Note**: Additional documentation and review may be required.
Splits If the company maintains or inherits the same employees (covered prior to the split)	First of the month following receipt of all documentation	1. Letter/email from group signed by owner/officer requesting the name change 2. New *Employer Application* 3. *Employee Enrollment Applications* for those enrolling in the new entity, as well as the termination request(s) from the prior group 4. Federal Tax ID Letter, Fictitious Business Name Filing (sole proprietorship or partnership), or Articles of Incorporation (corporations), or Articles of Organization (Limited Liability Corp [LLC]) 5. The most recent *Quarterly Wage and Withholding Report* for the original company indicating the status of each employee and who is going where 6. Eligibility Statement for owners not listed on *Quarterly Wage and Withholding Report* **Note**: Additional documentation and review may be required.
Mergers If a company insured with Anthem is merging with another company also insured by Anthem	First of the month following receipt of all documentation	1. Letter/email from owner/officer of surviving group explaining and requesting the change 2. New *Employer Application* 3. Legal documentation of the merger 4. The most recent *Quarterly Wage and Withholding Report* from each *company, with the status of each employee* 5. *Employee Enrollment Applications* for all new employees enrolling or waiving coverage 6. Eligibility Statement for owners not listed on *Quarterly Wage and Withholding Report* along with documentation of ownership 7. Prior carrier bill **Note**: Additional documentation and review may be required.

Benefit modification	When eligible	Documents necessary
Acquisition If a company insured with Anthem is acquiring another company **not** insured with Anthem	First of the month following receipt of all documentation	1. Letter/email from group signed by owner/officer explaining and requesting the change 2. Legal documentation of the acquisition 3. The most recent *Quarterly Wage and Withholding Report*, with the status of each employee 4. New *Employer Application* 5. *Employee Enrollment Applications* for all new employees enrolling or waiving coverage 6. Prior carrier bill from acquired company **Note**: Additional documentation and review may be required.

Maintenance

ID cards and Evidence of Coverage/certificates

ID cards

Anthem ID cards will be mailed to enrolled employees/members at their home addresses, unless the members choose to receive their ID cards electronically. Members can download ID cards from our secure website at anthem.com/ca or by using the Anthem Anywhere app. Additional and/or replacement ID cards can be ordered online through EmployerAccess, the secure member website (anthem.com/ca) or by calling Customer Service.

Combined Evidence of Coverage

All enrolled employees may download the *Combined Evidence of Coverage and Disclosure Form (EOCs)* by registering at anthem.com/ca. You may also access electronic copies of the EOCs through EmployerAccess. Please be aware that you will also need to make printed copies available to your employees upon request.

Anniversary dates

Your anniversary date is the month and day when the group's plan and/or policy became effective and coverage started, unless an anniversary change has been approved within the lifetime of a group.

The anniversary date cannot be changed unless mutually agreed upon; any exceptions will be equally applied to all groups. The following actions and changes can only occur on that date:

- Change from one type of plan to another type of plan that you already offer
- Request that part-time employees be added as a class of eligible employees
- Request to add employees and/or dependents who previously declined coverage or missed their original enrollment opportunity

All changes are effective on your group's anniversary date. If your group's original effective date is the 15th of the month, your anniversary date is the first of the following month (for example, if the original effective date is January 15 of one year, then the anniversary date is February 1 each year after that). If the anniversary month changes from one calendar year to another calendar year as a result of your request, **rates and benefits will change.**

Converting part-time employees to full-time employees (and vice versa)

Coverage for eligible part-time employees is considered an extension of eligibility and is offered at your discretion. If you choose not to offer benefits to part-time employees, then part-time employees cannot enroll. The enrollment procedures for new employees apply, including completing and submitting an *Employee Enrollment Application* within 45 days of the employee becoming full time.

Part-time employees who have worked less than 12 months

For employers that do not offer part-time coverage, the employee's enrollment is subject to the group-imposed waiting period. The waiting period begins on the date the employee begins full-time employment. Previous part-time employment is not credited toward the group-imposed waiting period.

Part-time employees who have worked more than 12 months

For employers that do not offer part-time coverage, part-time employees who become full-time employees are eligible to enroll as of the date they become full-time employees. Previous part-time employment is not credited toward the group-imposed waiting period unless the employee has worked continuously for at least one year.

You are responsible for informing us about the employment status of employees in a timely manner. When a full-time employee becomes a part-time employee and the group plan and/or 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 employee's change to part-time status. Electronic enrollment is Small Group's new standard to delete employees from your plan. If you have opted out of electronic enrollment, please submit these changes on a *1-100 Small Group Information Change Form*. (See *Eligible employees* for definitions of full-time and part-time.) Once coverage ends, the employee may have the option to continue coverage under COBRA or Cal-COBRA benefits. (See *Continuation of coverage* for more information.)

Changes in ownership

You must notify Anthem in writing about any changes in the company's ownership. The written notice must contain full details, including name change, federal tax ID number change, a copy of the buyout agreement, sale of assets agreement or other agreement that resulted in the change. Continued coverage and premium rate changes for the group as a result of these changes is subject to underwriting review and approval. The 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.

Canceling group coverage

If you decide to end your group's coverage, a written request must be sent to us. See the grid below for time frames. The written notice must be on company letterhead and be signed by an owner/officer or authorized representative of the company and include the termination date. You are responsible for notifying employees in a timely manner when coverage has been canceled. This includes COBRA and Cal-COBRA participants.

Examples of effective dates for groups requesting to cancel

	Example 1 of group cancellation	Example 2 of group cancellation
Request to cancel	April 1, 2018	April 1, 2018
Request received	April 25, 2018	May 6, 2018
Effective date	April 1, 2018	May 1, 2018

Cancel/Nonrenewal of coverage

Anthem reserves the right to cancel/not renew group coverage for reasons including, but not limited to, the following:

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

You are responsible for informing employees when coverage has been terminated.

Leaves of absence

Short-term personal leave of absence

You determine the length of time, up to three months, that health benefits will remain in effect under the plan if an employee takes a short-term personal leave of absence. If you approve the leave, enrolled employees are eligible to continue group coverage for themselves and their enrolled dependents for the period of time indicated in your group's application. Monthly premiums will continue to accrue during an employee's short-term personal leave of absence, and you must continue to pay the required monthly premiums. However, you can request that the employee pay the premiums directly to you during this period.

Anthem has no obligation and you are not required to continue coverage during an employee's short-term personal leave of absence for longer than the period indicated in your group's application. After the time period for continued coverage ends, an enrollee can elect to continue coverage under COBRA or Cal-COBRA, as applicable.

You are responsible for notifying us about an employee's short-term personal leave of absence begin and end dates.

Short-term medical leave of absence

You determine the length of time, up to six months, that health benefits will remain in effect under the plan if an employee takes a short-term medical leave of absence. If you approve the leave, enrolled employees are eligible to continue group coverage for themselves and their enrolled dependents for the period of time indicated in the group application. Monthly premiums will continue to accrue during an employee's short-term medical leave of absence, and you must continue to pay the required monthly premiums. However, you can request that the employee pay the premiums directly to you during this period.

Anthem has no obligation and you are not required to continue coverage during an employee's short-term medical leave of absence for longer than the period indicated in your group application. After the time period for continued coverage ends, an enrollee may continue coverage under COBRA or Cal-COBRA, as applicable.

You are responsible for notifying us about an employee's short-term medical leave of absence begin and end dates.

Filing a claim

To claim benefits, a member must submit a properly completed claim form that itemizes the services or supplies received and the applicable charges. All claims should be submitted to the address on the member's ID card. Please refer to your *Certificates* and/or a *Combined Evidence of Coverage and Disclosure Form* (EOCs) for additional guidance/requirements on services and or supplies. See *Important contact information* to find the address where you can send your claim forms.

Coordination with Medicare

Your group's Anthem Small Group plan **does not** provide supplemental coverage to Medicare recipients, but we do coordinate coverage with Medicare. Under The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)/Deficit Reduction Act (DEFRA) requirements, an Anthem medical plan and/or policy is the primary payer for businesses with 20 or more employees, regardless of how many enrollees are covered under the plan. For groups with fewer than 20 employees, Anthem is the secondary payer to Medicare and does not duplicate benefits that might be available under Medicare. Anthem determines its benefits, subtracts them from the benefits that are paid or payable under Medicare and pays the difference. Anthem is the primary payer when a group employs more than 100 employees and the Medicare recipient is disabled and under age 65.

Medicare eligibility reason	Primary payer
Aged 65 or older and covered by a group health plan because of current employment of member or spouse ○ Employer has 20 or more employees ○ Employer has less than 20 employees	 Anthem Medicare
Under 65, Medicare disabled ○ Employer has 100 or more employees ○ Employer has less than 100 employees	 Anthem Medicare
ESRD (permanent kidney failure), any age, any size employer ○ First 30 months after Medicare eligibility ○ After 30 months	 Anthem Medicare

Anthem will not provide benefits that duplicate any benefits a beneficiary is entitled to receive under Medicare. This means that when Medicare is the primary health coverage, we provide benefits in accordance with the benefits of the Anthem plan, less any amount paid by Medicare.

Medicare Part A and Part B beneficiaries will be eligible for non-duplicate Medicare coverage, with supplemental coordination of benefits. However, if they are required to pay the Social Security Administration an additional premium for any part of Medicare, then the above plan and/or policy only applies if they are enrolled in that part of Medicare.

You are responsible for notifying Anthem about changes in group size that also change your group's Medicare and COBRA/Cal-COBRA status.

About your billing

Premium rates

The following information applies to Small Group employers as defined by the California Health and Safety Code.

Various provisions of the law govern how often benefits or rates may change for your group and subscribers within the group. The types of changes we can make to your group's health premiums, including how often certain changes can be implemented, are limited. Rate changes are driven by rising health care costs and economic conditions, and it isn't possible to predict when or if a change may be necessary. If you're in a rate guarantee period when a rate change might occur, or you have a change to your employer group's principal business address, your group will not receive the increase until the date your guarantee period expires. Certain member-level changes may cause a rate change. Adding a dependent would be an example of what would cause a rate change. Age changes will be made at a group's anniversary.

The principal business address means the principal business address registered with the state of California or, if a principal business address is not registered with the state of California, or is registered solely for purposes of service of process and is not a substantial worksite for the policyholder's business, the business address within the state where the greatest number of employees of such policyholder works. If, for a network plan, the group policyholder's principal business address is not within the service area of such plan, and the policyholder has employees who live, reside, or work within the service area, the principal business address for purposes of the network plan is the business address within the plan's service area where the greatest number of employees work as of the beginning of the plan year. If there is no such business address, the rating area for purposes of the network plan is the rating area that reflects where the greatest number of employees within the plan's service area live or reside as of the beginning of the plan year.

Premium payments

Online payment is the new standard for Anthem Small Groups. We know that conducting business quickly, accurately and securely is important to you.

To work with you more efficiently, we're moving away from a paper-based system of invoicing groups and accepting payments. Anthem will issue your group billing statements and receive payments online through our EmployerAccess portal. The group will receive an itemized monthly bill from Anthem about one month before the bill due date. The bill will include the due date, total premium due, past due amounts, ACA fees and any other applicable fees.

Opting out

If you still need to pay by check or receive a paper bill, we can help you with that, too. Send an email with "Opt Out" in the subject line to: employeraccesssupport@anthem.com. Provide your group number, contact name, email address, phone number and reason for opting out of electronic billing.

Notification when bill is ready

When your group is signed up for online group billing, we will send you a notification email that your group bill is available. Use your secure credentials to sign in to EmployerAccess and review or print your bill, then pay now or schedule a payment. That's it!

Options for making your payment

Pay online

Paperless billing and payments are Anthem's new standard. Start paying your premiums online today. Electronic premium payments are faster and simpler than manual checks.

You can choose one of these ePayment options:

1. **EasyPay**, it's a **NEW**, super-fast, free self-service option to submit a single premium payment when you don't have time to log in to EmployerAccess. You simply make your payment as a GUEST user. All you need is a valid tax ID and your case or group number to get started. Visit easypay.anthem.com today.
2. **EmployerAccess** is a great way to pay your premiums online. Log in to EmployerAccess and set up your ePayments on the "*billing*" tab. It takes just a few minutes to pay your premium when you choose "*pay online now*." Plus, it's free and secure.

There is no fee for making payments online and payments only take one to two business days to post. Simply register for EmployerAccess to make a payment and/or schedule future payments. Need more details, visit EmployerAccess or call us at 1-855-854-1429.

The following options are only available to groups who have opted out of online payments. If you wish to opt out, please follow the directions above, under *Premium payments.*

Pay with check by mail

Mail your check and the coupon to:

Anthem Blue Cross
P.O. Box 51011
Los Angeles, CA 90051-5311

You can help us process the premium payment promptly by following these instructions:

- Always write your group number on the face of the check.
- Always send your coupon with the check.

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

Pay with check by phone

For a fee, you can call **1-855-854-1429** and pay by phone from your business checking account. An electronic Bank Authorization Form must be on file. There will be $10 fee for payments made by phone.

Please make sure to check that each monthly bill is accurate. Notify us immediately at 1-855-854-1429 if there are any discrepancies. It's important that the full amount of the premium listed on the bill is paid each month. Separate checks for each of the group's Anthem products are not required.

Adjustments to your bill – employee/dependent additions and deletions

It's important to pay the premium amount listed on your monthly bill. Please don't include premiums for new employees who are being added to the group or who don't appear on the bill. These premiums will be included on a later bill, after their applications are approved and processed. **If you are mailing your payment, please don't submit new applications or any correspondence with your bill.** Applications must be sent for new employees when they become eligible whether they are enrolling or declining coverage. (See *Important contact information* for submitting applications.)

Please don't adjust your premium payment with credit for deleted employees. Pay your premium as billed. Payments not made "in full" will subject your account to termination. We strongly suggest that you submit deletions to us as they happen,

so they're processed timely. Failure to submit eligibility change information in a timely manner could result in premium inaccuracies that you and/or your employees may not be able to recover. Credit for terminations will show on your next scheduled billing statement after we've processed the deletions. See COBRA for the employer's responsibility on submitting COBRA premium payments.

Important note: Please don't submit termination(s) with your premium payment. Terminations will not be processed because they will go to the premium payment lockbox, not directly to Anthem. Instead, please send terminations to the fax number shown on your billing statement. Failing to pay your premium or submitting membership changes by marking your bill does not meet the notification requirements for terminating an employee or dependent from your plan and/or policy. To submit member changes, refer to the *Enrollment actions guide*.

Administrative fees[1]

Administrative fees are due and payable with your next premium. Assessing a fee does not prevent future or additional fees to a single premium. We charge an administrative fee for the following reasons:

- **Premium payment by phone fee (for pay-by-check only)**

  We charge $10 for this service.

- **Reinstatement fee**

  If the plan and/or policy is canceled for not complying with the contract, and the plan and/or policy is later reinstated, there will be a $50 reinstatement fee. Paying the reinstatement fee is a condition of reinstatement, and it must be paid together with all outstanding premiums and any other administrative fees. **Approval or denial of a request for reinstatement is at Anthem's sole discretion.**

  Groups requesting reinstatements due to nonpayment will need to contact Accounts Receivable & Collections (ARC) at 1-888-686-9807.

- **Returned check fee**

  We will charge a $25 returned check fee if any instrument tendered as payment for all or part of your premium, or for any administrative fees, is returned unpaid for any reason.

  If we receive a check with a stop payment, it will incur the same fees as a returned check and will be subject to the provisions of any other dishonored check.

The following are just a few of the new fees and taxes required by the ACA:

- **Comparative effectiveness research (CER) fee**

  This fee funds a new Patient-Centered Outcomes Research Institute which examines the effectiveness, risks and benefits of medical treatments. It applies to fully insured and self-funded employer groups, and took effect in October 2012. We pay the fee for fully insured customers, but self-insured (ASO) plans must pay their own CER fees.

- **ACA insurer fee**

  This annual fee funds premium subsidies for the health care exchanges and Medicaid expansion. It applies to fully insured employer groups only. The fee will be included in your monthly bill.

1 Administrative fees are subject to change.

Nonpayment of premiums

We reserve the right to end your Small Group plan and/or policy for nonpayment. If you do not remit your payment on time, your Small Group plan and/or policy will be canceled, effective on the first day after the grace period ends. You have a 30-day grace period to pay your premium.* Since you have coverage throughout the grace period, premiums are due for that period. Failure to make your premium payment does not meet the notification requirements for canceling your Small Group coverage. See *Canceling group coverage* for information about how to cancel your Small Group coverage. You must pay premiums during your group's final month of coverage. If you do not pay the final month's premium, your account may be subject to collection.**

We must receive the payment on or before the due date shown on the bill, or it will be considered late. The Small Group plan and/or policy may be canceled if we do not receive the payment when it is due. Please allow at least seven days for mailing when making your monthly payment. See your group contract for more details.

* Payments are due and payable in full upon receipt. Payments received after the first day of the month for which coverage is in effect are deemed "late" and penalties may apply.

** Premiums must be paid in full by the end of the grace period (60 days for life coverage; 30 days for all other lines of coverage) in order for coverage to continue. See your plan and/or policy for grace period details. Reinstatement is at the absolute and sole discretion of Anthem and reinstatement fees will apply. If reinstatement is approved, you will be required to sign up for automatic recurring payments through EmployerAccess. Exceptions must be approved by Anthem.

Please note: Depositing of a check does not constitute acceptance of premium or a guarantee of coverage.

Enrollment guidelines

Eligible employees

- Permanent employees who are actively engaged on a full-time basis in the conduct of the business of the small employer with a normal workweek of an average of 30 hours per week over the course of a month, at the small employer's regular places of business, who has met any statutorily authorized applicable waiting period requirements.
- Sole proprietors, corporate officers, or partners of a partnership, if they are engaged on a full-time basis (average of 30 hours per week over the course of a month) in the small employer's business and included as employees under a health care service plan contract of a small employer over the course of a month.
- Permanent employees who work at least 20 hours per week, but not more than 29 hours per week, are deemed to be eligible employees, if all four of the following apply:
  - They otherwise meet the definition of an eligible employee except for the number of hours worked.
  - The employer offers the employees health coverage under a health benefit plan.
  - All similarly situated individuals are offered coverage under the health benefit plan.
  - The employee must have worked at least 20 hours per normal workweek for at least 50% of the weeks in the previous calendar quarter. Anthem may request any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.

Employees living outside of California

Employees who live outside California may only be eligible for PPO plans in the Statewide Prudent Buyer network and Select PPO network. **At least 51% of all eligible employees must be employed in California**.

Residents of Hawaii

HAWAII ALERT — Since Anthem is neither a Hawaii authorized insurer nor a Hawaii Health Care Contractor, our benefits may not match the requirements of the Prepaid Health Care Act. We recommend that you obtain direct quotes for either an individual plan and/or policy for employees who live and work in Hawaii or if there are several employees within an employer group, to obtain group coverage from a Hawaii authorized insurer. This would ensure that all the state requirements are met.

Ineligible employees

Seasonal employees, temporary or substitute employees, defined as employees hired with a planned future termination date, are not eligible. Employees compensated on a 1099 basis are not eligible.

Eligible dependents

An eligible employee may be required to provide proof of dependency. Dependent coverage is available to the following:

- Lawful spouse
- Registered domestic partner (Family Code Section 297)
- Disabled dependent child who, at the time of becoming age 26, is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition, and is chiefly dependent on the subscriber for support and maintenance.
  - A disabled dependent may be eligible for benefits beyond his or her 26th birthday.
  - The employee will be required to submit certification by a doctor of the child's condition.
- An employee's, spouse's or registered domestic partner's child under age 26:
  - Natural child
  - Newborn child
  - Stepchild
  - Legally adopted child
  - Ward of a permanent legal guardian
  - Child for whom the eligible employee has assumed a parent-child relationship (does not include foster children), as indicated by intentional assumption of parental status or assumption of parental duties by the eligible employee[1]

To be eligible to enroll as a dependent, that individual must be listed on the *Enrollment Form*.

The application for coverage for a dependent child must be submitted to Anthem within 60 days of the child's eligibility. Coverage will be effective beginning on the date of birth or "event date" following our receipt of the completed and approved *Employee Enrollment Application*. A child will be considered adopted from the earlier of: 1) the moment of placement in your home; or 2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted, unless the child is removed from your home prior to issuance of a legal decree of adoption.

If both parents are covered subscribers through the same employer, their children may be covered as dependents of either, but not both, of the subscribers. All dependent children have 60 days to submit applications from the date of qualifying event (marriage, birth, etc.). New spouses and/or domestic partners also have 60 days from qualifying event date.

What is a "domestic partner"?

Domestic partner is defined in Family Code Section 297 as follows:

- Domestic partners are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring.
- A domestic partnership shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State pursuant to this division, and, at the time of filing, all of the following requirements are met:
- Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
- The two people are not related by blood in a way that would prevent them from being married to each other in this state.
- Both people are at least 18 years of age.
- Either of the following:
  - Both people are members of the same sex except as provided in section 291.1.
  - One or both of them meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership, unless one or both of them are over the age of 62.
  - Both people are capable of consenting to the domestic partnership.

1 As certified by the employee or annuitant at the time of enrollment of the child, and annually thereafter.

Children's age/qualification criteria

To be eligible for coverage, a dependent child, stepchild or ward must meet one of the following age/qualification criteria:

- Be a child of the subscriber or the subscriber's enrolled spouse/registered domestic partner, up to the child's 26th birthday.
- Be an over-age dependent of the subscriber or the subscriber's enrolled spouse/registered domestic partner who, at the time of becoming age 26, is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition, and is chiefly dependent on the subscriber for support and maintenance. See *Over-age dependents* for information about the documentation and time frames required for continuing coverage for dependents who have reached the limiting age. (A disabled dependent may be eligible for benefits beyond his or her 26th birthday.)

Applications with missing information are considered incomplete and will be returned for completion. We must receive a fully completed application within the eligibility period.

Enrolling eligible dependents

Type of dependent	Application for coverage or declining coverage must be received:	And must include (if requesting coverage):
New spouse or new domestic partner Coverage will begin on the event date following our receipt of documentation: • New spouse: *Employee Enrollment Application* • Same-sex new domestic partner: *Employee Enrollment Application* • Opposite-sex new domestic partner: *Employee Enrollment Application*	Within 60 of new marriage or new domestic partner registration	*Employee Enrollment Application*
Newborn child The child will be covered for the first 31 days from the date of birth. Coverage will continue beyond the 31 days, provided that the employee submits an application/change form to the group within 60 days from the date of birth to add the child to the plan. If the employee submits an application/change form to the group within 60 days from the date of birth, coverage for the child under the plan will be effective beginning on the date of birth.	Within 60 days of birth	*Employee Enrollment Application/Employee Change Form*
Adopted child In the case of adoption, or placement for adoption, the child will be covered for the first 31 days from the date of adoption, or placement for adoption. Coverage will continue beyond the 31 days, provided that the employee submits an application/change form to the group within 60 days from the date of adoption or placement for adoption to add the child to the plan. If the subscriber submits an application/change form to the group within 60 days from the date of adoption or placement for adoption, coverage for the child under the plan will be effective beginning on the date of adoption or placement for adoption. • A child will be considered adopted from the earlier of: 1) the moment of placement in the subscriber's home; or 2) the date of an entry of an order granting custody of the child to the subscriber. The child will continue to be considered adopted unless the child is removed from the home prior to issuance of a legal decree of adoption.	Within 60 days of adoption or placement for adoption	*Employee Enrollment Application/Employee Change Form* Legal evidence of authority to control the health care needs of the child
Stepchild A child of the subscriber's spouse or registered domestic partner	Within 60 days of marriage or domestic partner registration	*Employee Enrollment Application*

Type of dependent	Application for coverage or declining coverage must be received:	And must include (if requesting coverage):
Ward of a permanent legal guardian An unmarried child (ward) of a subscriber or the subscriber's enrolled spouse/domestic partner who is named the **permanent** legal guardian by a final court decree or order will be considered an eligible dependent child, subject to all rules and age limitations that apply to an eligible dependent child.	Within 60 days of issuance of the final court decree or order of legal guardianship (or, if specified, within the time frame indicated in such court decree or order)	*Employee Enrollment Application* *Letter of Guardianship* form from the court, showing the filing date and court seal
Assumed parent-child relationship Child for whom the eligible employee has assumed a parent-child relationship (does not include foster children), as indicated by intentional assumption of parental status or assumption of parental duties by the eligible employee[1]	Within 60 days of qualifying event	Certification

Applications with missing information are considered incomplete and will be returned for completion. We must receive a fully completed application within the eligibility period.

Enrolling new employees

You can enroll a new employee (and dependents, if applicable) online through EmployerAccess.

To enroll, a new employee must complete an Employee Enrollment Application. We must receive the completed application after the employee's date of hire and no more than 45 days after the employee's eligibility date. The eligibility date is the first of the month following the group's imposed waiting period. (See the chart under *Coverage effective dates*.) If we get an application more than 45 days after the employee's eligibility date, the employee will be considered a late enrollee and may not be eligible for coverage until the next open enrollment period without a qualifying event. (See *Late enrollees/open enrollment*). The employer is responsible for assuring all eligible employees who are not enrolling onto the coverage complete the waiver requirements. See the *Enrollment actions guide* for waiver options.

We recommend that you submit an application immediately after an employee is hired. Coverage will not begin before the applicable group-imposed waiting period is over.

Please note: There are **no exceptions** to these requirements. Incomplete applications will not be processed, which may delay the employee's coverage effective date.

Remember, you can also enroll a new employee (and dependents, if applicable) online through EmployerAccess. See Online enrollment in the *Self-service options* section. If you aren't already registered for EmployerAccess, please call us at 1-855-854-1429 for details.

When paying your bill, please do not add premiums for new additions or enrolling a new employee. These changes will be reflected on a later bill.

All individuals enrolled in Small Group coverage outside of a public exchange/Marketplace are required to have coverage for pediatric dental essential health benefits (even if they do not have dependent children, as mandated by the Affordable Care Act).

1 As certified by the employee or annuitant at the time of enrollment of the child, and annually thereafter.

Coverage effective dates

Anthem will determine the coverage effective date for new employees and their dependents. That date depends on the following:

- The date of hire
- A group-imposed waiting period, which is the period of time that must pass between an employee's hire date and the date the employee is eligible to enroll in or decline to participate in the employer's benefit plan
- Late enrollee classification, as defined under the Health Insurance Portability and Accountability Act (HIPAA)
- The date we receive the fully completed application

Effective dates are determined as follows:

- **Example 1:** If we receive the fully completed application before the employee's group-imposed waiting period is over, the effective date will be the first day of the month following application approval and waiting period.
- **Example 2:** If we receive the fully completed application after the employee's eligibility date, but within 45 days of the date when the employee becomes eligible, the effective date will be the first of the month following the completion of the group-imposed waiting period.
- **Example 3:** If we receive the application more than 45 days after the employee's eligibility date or if the employee waived coverage, the applicant will be considered a late enrollee as defined under HIPAA, and the effective date will be delayed until a group's open enrollment or an approved qualifying event.
- **Example 4:** If we receive the fully completed application with the date of hire as the first of the month and the group imposes a first of the month following date of hire waiting period, the effective date will be the first of the following month.

Applications with missing information are considered incomplete and may be returned. **In those cases, we will use the date that we receive the fully completed application to determine the coverage effective date**. We must receive fully completed applications before the requested coverage effective date and within the eligibility period. Eligibility date is the date that the employee is eligible to become effective. The eligibility date for existing employees and dependents is the employer's effective date, unless new hires have not yet satisfied their employer's imposed waiting period. The effective date for these employees will be the first of the month following completion of the waiting period and submission of the *Employee Enrollment Application*.

Examples of effective dates for eligible employees

In this example, the group's waiting period is the first of the month following one month.

	Example 1 Employee submits application within the timeframe	Example 2 Employee submits application after eligibility date (within 45 days)	Example 3 Employee submits application more than 45 days after eligibility date	Example 4 Employee submits application, the group's waiting period is first of the month after hire date
Hire date	April 10, 2018	April 10, 2018	April 10, 2018	April 10, 2018
Eligibility date	June 1, 2018	June 1, 2018	June 1, 2018	May 1, 2018
Completed application received	June 15, 2018	July 1, 2018	August 1, 2018	April 15, 2018
Effective date	June 1, 2018	June 1, 2018	Group's next anniversary or approved qualifying event	May 1, 2018

Enrolling rehired employees

If an enrollee's employment ends and the employee is later rehired, certain restrictions apply. If the employee is rehired **within** 31 days of termination, coverage will resume with no lapse upon our receipt of a written request from the employer group. If the employee is rehired **more than** 31 days after the termination date, the employee is considered a new employee, subject to applicable group-imposed waiting periods and must complete a new *Employee Enrollment Application*. The group is responsible for notifying us immediately if an employee is rehired and will be continuing coverage.

Waivers

New employees who do not elect coverage or existing employees who choose to end coverage under your Anthem Small Group plan and/or policy must complete sections A and F of the Employee Enrollment Application or submit the *Employee Waiver Form*. We must receive the application after the hire date and before the last day of the month following the end of your group's waiting period. You are responsible for ensuring that we receive applications from employees who are waiving coverage within the same time frame as applications from employees who are requesting coverage. (See *Enrolling new employees*.) Depending on why an employee chooses to waive coverage, they may be eligible to reapply at a later date with a valid qualifying event.

Late enrollees/open enrollment

If we receive a new *Employee Enrollment Application* more than 45 days after the applicant becomes eligible, the subscriber and eligible dependents will be considered late enrollees and will have to wait until the group's anniversary date for coverage. This time period is known as "open enrollment." During open enrollment, a group can submit an application 60 days prior to its anniversary date and up to 30 days after. For example, if a group's anniversary date is April 1, 2018, it can submit February 1, 2018, through April 30, 2018.

The process for open enrollment is the same as if you were adding an employee on your health plan's anniversary date. All employees and/or eligible dependents that previously waived coverage and now want to enroll must complete an *Employee Enrollment Application*. We must receive the application no later than the last day of your group's anniversary month. You can verify your anniversary date by calling Customer Service.

Please see the *Certificates* and/or a *Combined Evidence of Coverage and Disclosure Form* (EOCs) for exceptions that apply to special enrollment periods.

Qualifying events

Employee and/or dependents that experience a qualifying event have 60 days to submit a completed application. Coverage will begin on the event date. Below lists examples of qualifying events:

- Open enrollment (not applicable for life)
- Marriage or Declaration of Domestic Partnership
- Birth or adoption of a child
- Involuntary loss of coverage
- Death
- Divorce or legal separation

Where to submit applications

Here's how you can submit completed *Employee Enrollment Applications*:

By mail:	Anthem Blue Cross Small Group Services P.O. Box 9062 Oxnard, CA 93031-9062
By fax:	1-855-750-2227
Online:	Enroll employees through EmployerAccess

Enrollment actions guide

	How this action can be done										
	Electronic[1,2]						Paper				
	Employer Portal (Online tools)										
Action	EmployerAccess	Online Member Enrollment	Online Census Enrollment	Offline Census Enrollment	Electronic File (834/1000 format)	Real-time	Employer Application	Employee Enrollment Application	1-100 Small Group Information Change Form	Employee Change Form	Employee Waiver
Add a **new** employee and/or dependents to the plan	✓	✓	✓	✓	✓	✓		✓			
Add dependents for an **existing** employee	✓			✓	✓	✓		✓		✓	
Waive coverage for an employee and/or dependents	✓	✓				✓		✓		✓	✓
Change plans for employees or dependents who already have coverage	✓			✓	✓	✓		✓		✓	
Terminate an employee and/or dependents from the plan	✓			✓	✓	✓			✓		
Discontinue coverage for employees and/or dependents who still remain eligible under the plan	✓			✓	✓	✓		✓	✓	✓	✓
Change an employee's address	✓			✓	✓	✓		✓	✓	✓	
Notify us about a COBRA or Cal-COBRA qualifying event for an employee and/or dependents already enrolled in the plan	✓			✓	✓	✓			✓		
Remove a subscriber from federal COBRA	✓								✓		
Change the employer's address (This may affect the employee's rate.)	✓						✓		✓		

1. The group may submit initial and ongoing eligibility data in a format defined by Anthem to be compatible with Anthem's system. The group may contract with a third-party vendor to capture initial and ongoing eligibility data in order to electronically send data to Anthem. See *Electronic enrollment and eligibility data submission guidelines* for more information.

2. If you have questions or are interested in starting electronic enrollment, please contact your sales representative or see *Important contact information*.

More details about our electronic enrollment options:

- *EmployerAccess* – Online tool for brokers or groups to perform enrollment changes
- *Online Member Enrollment* – Online tool for members to perform enrollment changes
- *Online Census Enrollment* – Online tool for brokers or groups to process large volumes of enrollment changes
- *Offline Census Enrollment* – Offline tool for brokers or groups to email large volumes of enrollment changes
- *Electronic File (834/1000 format)* – Electronic file feeds for brokers or groups to perform enrollment changes
- *Real-time* – Solution used to submit large enrollment volumes

Electronic enrollment and eligibility data submission guidelines

- The group may submit initial and ongoing eligibility data in a format defined by Anthem to be compatible with Anthem's system. The group may contract with a third-party vendor (vendor) to capture initial and ongoing eligibility data in order to electronically send such data to Anthem. The group or its authorized vendor will administer and maintain all electronic eligibility in accordance with the provisions of the Business Associate agreement and the group shall be responsible for the performance and activities of the vendor. The group must obtain Anthem's approval in writing prior to initiating the submission of electronic eligibility data to Anthem. Anthem will not be responsible for any fees or administrative charges associated with any vendor services purchased by the group. All fees or administrative charges will be the sole responsibility of the group.
- If the group uses electronic enrollment applications in place of paper enrollment application forms provided by Anthem, the group warrants and agrees that the electronic enrollment processes and media will: (a) include an arbitration disclosure provision with language acceptable to Anthem and be located immediately before the electronic signature;and (b) be maintained in a secure manner, which can be retrieved, and be reproduced with the enrollment form and signature linked with the process or media. In addition, the group warrants that the manner of electronic signature satisfies all legal requirements for an electronic signature. The group agrees to procure Anthem's prior approval for any nonstandard application forms prior to use. The group shall maintain the signed arbitration provisions for the duration of this contract, plus four years.
- On or before the end of each month, the group or its vendor will electronically transmit to Anthem the eligibility information using software mutually acceptable to both Anthem and the group. The transmission must contain a listing for the current month of all subscribers and family members enrolled under the agreement. The listing will also include newly enrolled members, deleted members who are no longer eligible, and any other changes related to eligibility. Upon receipt of the information from the group, Anthem will update its membership data with the current enrollment information contained therein.
- The group will provide for the establishment and ongoing retention of membership information. This will include obtaining and maintaining applications from eligible subscribers or family members who might otherwise qualify for coverage separate from the primary subscriber, and the handling of ongoing additions, deletions and changes to the membership list on a timely basis. The group will likewise be responsible for retaining, in auditable form, the complete enrollment and eligibility documentation, whether written or in electronic form, including, but not limited to, all electronic or written enrollment applications, any electronic or written confirmation forms or media, and any electronic or written correspondence related to the enrollment, eligibility and waiver or declination forms. The group must procure Anthem's prior approval for any nonstandard forms to be used in securing enrollment and eligibility information. The group agrees to maintain all membership information in a secure manner, retrievable and reproducible, including all signed enrollment applications linked with the process or media. The group will furnish to Anthem, immediately upon Anthem's demand, and at no expense to Anthem, copies of such forms and correspondence, whether written or electronic. Eligibility guidelines based upon criteria set forth in this agreement must be adhered to.
- The group and Anthem shall comply with all applicable requirements of HIPAA and the group, and Anthem shall require any of their respective agents, subcontractors and vendors to comply with all applicable requirements of HIPAA.

When to send enrollment forms
See *Enrollment guidelines*.

When medical benefits become active
See *Employer waiting periods*.

Arbitration language
Anthem Blue Cross arbitration language is a condition for enrollment and all new enrollees must sign the arbitration language that appears on our Anthem enrollment forms. Please refer to the last page.

Summary of Benefits and Coverage (SBC)

The Affordable Care Act (ACA) requires that all members of fully insured medical plans receive an SBC. Groups are responsible for sending an electronic or printed copy of the SBC to participants and beneficiaries. SBCs can be accessed at www.sbc.anthem.com. Click here to view step-by-step instructions for how to access your SBCs.

Membership changes

Plan changes

Covered subscribers may move to a different plan and/or product offered by the group at the anniversary month. Plan changes may also occur with a qualifying event or special open enrollment. This can be done by submitting a letter from the group on company letterhead explaining the request to change or by completing the *Plan Change Request Form* on the anniversary date.

Canceling employees from the plan

Electronic enrollment is Small Group's new standard to delete employees from your plan. If you have opted out of electronic enrollment, please complete section 2 of the *1-100 Small Group Information Change Form* for the following:

An employee's coverage under the plan must be canceled if:

- Employment is terminated.
- An eligible full-time employee changes to a part-time employee, and your plan does not cover part-time employees.
- An employee is on a leave of absence (medical and/or personal) and the time period that the employer covers employees on leave has expired.
- An eligible part-time employee's work is permanently reduced to less than the minimum number of hours per week, based on whether you have elected to offer coverage for those who work 20–29 hours per week.
- An eligible employee becomes ineligible by becoming seasonal, temporary, substitute or 1099.
- An employee otherwise becomes ineligible to participate in the plan.
- The employee no longer wants to continue federal COBRA coverage.

Please include the following information:

- Employee name
- Social Security number or member ID number
- Updated address (if applicable)
- Date of birth
- Termination date (last day worked)
- Request for COBRA (only complete if enrolling) or Cal-COBRA
- Qualifying event for termination

Please fax termination notices to us at 1-855-750-2227 or mail them to:

Anthem Blue Cross
Small Group Services
P.O. Box 9062
Oxnard, CA 93031-9062

Please do not include the *1-100 Small Group Information Change Form* with termination information or any correspondence with your monthly payment.

You are required by law to allow eligible employees to remain on the plan until their employment is terminated. The termination will be effective the first of the month following the last day of employment. Timely notification of terminations is required to ensure that coverage does not extend beyond the month when the termination occurred and to comply with COBRA and Cal-COBRA notification requirements. When notification is delayed, we are unable to cancel coverage in a timely manner, which results in continued coverage for ineligible employees and dependents.

Due to applicable state law, retroactive plan and/or policy terminations are not allowed. When a member's employment is terminated, the employee must be canceled from the group. Employees who elect to continue coverage under COBRA must

still be canceled from the plan. After Anthem is notified about the COBRA election, the member will be enrolled under your COBRA benefits.

You are obligated under law and by contract with Anthem to notify employees of their termination of coverage and of any rights to continue coverage. Failure to do so exposes you to liability to the employee and to Anthem. When preparing your monthly premium payment, please do not delete any premiums for canceled members. A credit for the deletion will be reflected on a future billing.

Anthem does not accept retroactive terminations.

Canceling employees who remain eligible but discontinue coverage

Electronic enrollment is Small Group's new standard to delete employees from your plan. See the *Enrollment actions guide* for more information on electronic enrollment.

All employees and/or eligible dependents that previously waived coverage and now want to enroll must complete an Employee Enrollment Application. The coverage effective date may be delayed until your group's anniversary date or an approved qualifying event.

Employee termination dates

	Example 1	Example 2
Last day worked	April 3, 2018	April 3, 2018
Requested employee cancellation	May 1, 2018	May 1, 2018
Request to cancel received	April 1, 2018	June 15, 2018
Effective date of cancellation	May 1, 2018	June 1, 2018

- Employees who worked on the first of the month will not be taken off the plan and/or policy until the first of the following month.
- Cancellation dates are the first of the month only with the exception of the death of a subscriber with no enrolled dependents.

Employees turning 65

Medicare is the primary payer for employees age 65 or older in employer groups with fewer than 20 employees (based on 20 or more calendar weeks in the previous calendar year). Anthem is not a supplement to Medicare.

For information about their coverage options, employees who are approaching age 65 should consult their *Certificates* and/or a *Combined Evidence of Coverage* and *Disclosure Form* or contact Customer Service before they become eligible for Medicare. Those members should also contact the Social Security Administration before they turn 65.

Employers with 20+ employees

Employers subject to the Medicare secondary-payer laws (generally those with 20 or more employees) may not discriminate against their employees who have become eligible for Medicare benefits:

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

For more information about their coverage options, employees who are approaching 65 should consult their *Certificates* and/or a *Combined Evidence of Coverage and Disclosure Form* (EOCs) or contact Customer Service before they become eligible for Medicare. **Those members should also contact the Social Security Administration office before they turn 65.**

Extension of benefits

The plan provides for a limited extension of benefits if coverage ends, the member is totally disabled and certain other criteria are met. The extension (up to 12 months) covers only totally disabling conditions. It is subject to review every three months. An extension of benefits must be requested in writing or by calling our Customer Service department within 90 days of the cancellation of coverage. (See *Continuation of coverage* for more information.)

Over-age dependents

The group plan allows for coverage of over-age dependent children up to age 26. At that point, they are no longer eligible for benefits under the plan, except under certain circumstances, and coverage will be canceled on the first day of the month following their 26th birthday.

Coverage for over-age dependent children may be extended beyond the child's 26th birthday if certain conditions are met and the parent provides the required documentation to Anthem. When a dependent child's coverage terminates because the child has reached the limiting age, we will notify the subscriber at least 90 days before the child has reached that age. The subscriber must then submit a request for continued coverage for the child, along with proof of the applicable criteria described below, within 60 days of receiving our notification. Once we receive the subscriber's request and proof of the applicable criteria, we will determine whether the child is eligible for continued coverage before the child reaches the limiting age. If we do not determine eligibility by that date, coverage for the child will continue, pending our determination.

The subscriber can continue coverage for an over-age dependent child when one of the following conditions exists and we receive the required documentation described below:

For a child who is incapable of self-sustaining employment due to a physically or mentally disabling injury, illness or condition, and who is at least one-half dependent upon the subscriber for support and maintenance: Complete the *Handicapped Dependent Certification Form*. A doctor must certify the dependent's physically or mentally disabling injury, illness or condition in writing. After a dependent child reaches the limiting age and has been continually enrolled for two years, we may request proof, no more frequently than annually, of the child's continuing dependency and that a physically or mentally disabling injury, illness or condition still exists.

If the requested coverage is due to a court order: An application for coverage, along with a copy of the court order must be submitted to us within 60 days from the date the court order is issued. We may request information about the dependent child initially, and then no more frequently than annually, to determine if the child continues to meet the coverage criteria.

To replace previous coverage with Anthem coverage: We will then determine whether the child meets the criteria for continued coverage. We may request information about the dependent child initially, and then no more frequently than annually, to determine if the child continues to meet the applicable criteria for coverage.

Continuation of coverage

When a member's employment with your company ends, he or she **must be canceled** 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, we will re-enroll the member with COBRA or Cal-COBRA coverage with no lapse in coverage. Your group must be active. Member eligibility on Cal-COBRA is dependent upon your group retaining active coverage.

You are obligated by law and by contract with Anthem to notify employees about coverage termination and about their rights to continue coverage. Failure to do so may expose you to liability to the employee and to Anthem.

You are responsible for notifying us in a timely manner about changes in group size that cause changes in your group's Medicare and COBRA status. The Cal-COBRA, COBRA and Medicare survey is available on Easy Renew.

Cal-COBRA

Under California law, Cal-COBRA provides continuation of coverage for groups that employ from 1 to 19 eligible employees for at least 50% of the working days in the previous calendar year. Groups of 1 employee are not eligible for Cal-COBRA.

Employees and their eligible dependents are eligible for continuation of coverage under Cal-COBRA for up to 36 months if coverage was terminated due to any of the following qualifying events:

- The plan subscriber dies (continuation of coverage for dependents)
- The employee's employment is terminated
- The employee's hours are reduced and he or she is no longer eligible
- The spouse divorces or legally separates from the subscriber, or a registered domestic partnership is legally terminated
- An enrolled child is no longer eligible as a dependent (Over-age dependents)
- The employee becomes eligible for Medicare (continuation of coverage for dependents)
- An enrolled family member is no longer eligible

The employer must notify us within 31 days from the date that the qualifying event occurred. Notification must be submitted in writing by completing Section 2 of the *1-100 Small Group Information Change Form*. The date and a description of the qualifying event must be included on the form.

Within 14 days of notifying us about a qualifying event, the subscriber will receive a notice from us about enrollment and premiums for the continuation of coverage. Continuation of coverage offers the same health, dental and vision coverage that was in effect when the subscriber's qualifying event occurred, excluding voluntary vision, voluntary dental, life and disability coverages. The subscriber's coverage is subject to the same changes in benefits and premiums that affect the group plan. Eligible former employees and their dependents have a 60-day election period to decide if they will continue benefits under Cal-COBRA and an additional 45 days to make their initial payment in full. The plan and/or policy will not be active until election and payment are received.

We will bill the subscriber directly on a monthly basis for the premium. The subscriber is responsible for paying the premium in full each month. Premiums begin to accrue from the employee's coverage cancellation date under the group plan and/or policy. No lapse in coverage may occur. Premiums from the date of cancellation through the date of Cal-COBRA election are due. Failure to pay by the specified due date 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.

Cal-COBRA premiums include a 10% administrative fee.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Participation in the employer's benefit plan, as well as coverage under other health programs you provide 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 your obligation under this federal law. Anthem isn't responsible for COBRA administration. (See *POP, FSA and COBRA administration* for information about COBRA administration services offered by WageWorks.) You are responsible for providing satisfactory notice to employees about COBRA benefits, as well as disclosure and other administrative obligations imposed under the Employee Retirement Income Security Act (ERISA).

Eligible former employees and their dependents have a 60-day election period and 45 days from the day they elect COBRA to make the initial payment to decide if they will continue benefits under COBRA. You are responsible for notifying us about an employee's termination, and that the employee will continue coverage under COBRA. If an employee elects COBRA coverage within the 60-day election period, California will reinstate employee and/or dependent coverage retroactive to the original employment or coverage termination date, without a lapse in coverage. Continuation of coverage offers the same health, dental and vision coverage that was in effect when the subscriber's qualifying event occurred, excluding voluntary vision, voluntary dental, life and disability coverages.

Under California law, members who are 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.

Before a COBRA member reaches his or her end date, Anthem will notify the COBRA member about the option to extend coverage under Cal-COBRA for up to 36 months. This letter will also provide applicable Cal-COBRA rates. The COBRA member must respond, indicating whether he or she wants to extend coverage under Cal-COBRA.

Medicare Part D

A key element of the Medicare Part D benefit requires that employers provide either a "creditable" or "non-creditable" coverage notice to their employees. This notice is for all of your Medicare beneficiaries with prescription drug coverage.

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

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

The Medicare Modernization Act of 2003 requires employers to notify the Centers for Medicare and Medicaid Services (CMS) about the creditable/non-creditable nature of the prescription drug coverage they provide to their Medicare-eligible members.

For samples of coverage notices, please go to the CMS website at **cms.hhs.gov/creditablecoverage**, or call Medicare at **1-800-633-4227**.

Anthem and its affiliated companies have been chosen as a provider of Medicare Part D plan options. View a list of Anthem plans that are "creditable" or "non-creditable". For more information, your Medicare-eligible employees can contact your group's authorized independent agent, or they can call our Senior Services department at **1-866-892-5340**. They can also call Medicare directly at **1-800-633-4227**. TTY/TDD users can call **1-877-486-2048**, 24 hours a day, seven days a week.

Canceling COBRA members

COBRA members are subject to the same grace period as the group. If payment is not received within the specified grace period, you are responsible for deleting COBRA members in a timely manner. **We do not accept retroactive terminations beyond the original grace period**.

COBRA-eligible dependents

A dependent will become eligible for COBRA when the subscriber divorces or terminates his/her domestic partnership, the subscriber dies, a dependent child becomes over age, when the employee is terminated or the subscriber becomes eligible for Medicare. See the *Enrollment actions guide* for processing options.

You are responsible for notifying Anthem in a timely manner about changes in group size that cause changes in the group's Medicare and /or COBRA status. Please note that groups with under 20 employees are Cal-COBRA eligible. Groups with over 20 employees are federal COBRA eligible. If you use a third-party administrator (TPA) for your payroll/COBRA, you must still adhere to the above guidelines.

Connecting employees to health and wellness programs that save you money

Lower costs, higher productivity

Our priority is to make sure your employees get all the help they need to be their healthy best. That also helps improve the health of our communities while keeping your costs down. Here's a few of the programs, tools and resources we offer our members to help them stay healthy and productive.

Guide for a healthier lifestyle

- *LiveHealth Online* — Your employees can see a board-certified doctor or licensed therapist through live video on their smartphone, tablet or computer with a webcam. LiveHealth Online is quick, easy to use and will help your employees get the care they need when they need it.
- *24/7 NurseLine* — Round-the-clock, toll-free access to nurses who can answer general health questions and provide guidance about critical health concerns, as well as when and where to get care.
- *Future Moms* — Coaching, education and support throughout pregnancy from nurse coaches who can answer questions 24 hours a day.

Health management and coordination

- *ConditionCare* — Help for managing chronic conditions, such as asthma, diabetes, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD) and heart failure, ConditionCare helps members follow their doctor's plan of care.
- *MyHealth Advantage* — Employees get personalized reminders and messages, based on individual health information, to help them improve their health and lower health care costs. This program is included in all fully insured member plans, except those with a consumer-driven health plan component.
- *Case Management* — Offers one-on-one expert nurse coaching to help members find and receive the right services if they have a complicated medical situation.

Cost-effective resources and tools

anthem.com/ca — Our digital home is more than just a website. It's a health hub for your employees. Here, they can access their benefits, find in-network doctors, hospitals and other health care professionals that will save them money. They can estimate the cost of medical procedures and see which doctors have the highest performance and safety ratings. It's all about getting your employees healthier so they can go back to work faster.

Anthem Anywhere — Encourage employees to download the Anthem app to their smartphones to get instant access to their ID card, claims, find providers, fill prescriptions and more.

SpecialOffers@Anthem℠ — Discounts on health-related products and services, such as stop smoking programs, fitness club memberships and more to help employees live a healthier lifestyle.

AudioHealth Library — Access to more than 400 health topics by phone to keep employees informed about their health.

For more information on the health and wellness programs and resources available, please visit anthem.com/ca and select **Health and Wellness**.

Coverage while traveling (BlueCard Anthem Core for PPO medical plans)

With the BlueCard program, our PPO members who need care when they're traveling can enjoy the benefits of their Anthem membership anywhere in the United States (subject to the terms and payment provisions of their Anthem health plan).

BlueCard offers access — at great savings — to doctors and hospitals outside California that contract with Blue Cross plans in other states. We're talking about 96% of hospitals and 93% of doctors across the country.* The BlueCard program links them all together as one big network. In addition to cost savings, BlueCard offers the security of access to high quality health care, wherever our PPO members travel in the United States.

To locate a BlueCard PPO participating provider, members can call 1-800-810-2583.

* Blue Cross Blue Shield Association website, BlueFacts (accessed December 2016): bcbs.com/sites/default/files/file-attachments/page/BCBS.Facts_.pdf.

Life insurance

Offered by Anthem Blue Cross Life and Health Insurance Company

This section applies only if life insurance is included in your group's benefits package.

Premiums

Life insurance premiums are billed monthly and are combined with your group's other benefit premiums in one consolidated bill. (See *About your billing* for more information.)

Do not adjust your bill to reflect membership changes. Report changes on the *1-100 Small Group Information Change Form*. The changes will be reflected with any necessary adjustments on the next month's bill.

If the group collects premiums from individuals (for example, payroll deduction) the group is responsible for returning these premiums back to the individual covered under the plan and/or policy.

Enrolling new employees

An *Employee Enrollment Application* must be submitted to enroll a new employee in life insurance. (See *Coverage effective dates* for information about when we must receive applications.) Applicants who apply for coverage and submit their complete, signed enrollment forms within 45 days of their eligibility date will be added as of the original effective date.

However, if we receive forms after the 45-day eligibility period expires, the applicants are considered late enrollees and the following applies:

- In *contributory* groups (both the employer and the employees contribute to the monthly premium cost), the applicant must satisfy medical evidence underwriting; then, the applicant will be enrolled effective the first of the month following the approval date.
- In *noncontributory* groups (the employer pays 100% of the monthly premium cost), the applicant's enrollment will be effective on the same date as the employee's original eligibility date, and the employer will be responsible for any premium amounts due during the interim. If the requested life amount is over the guaranteed issue amount, the applicant must then satisfy medical evidence underwriting.

As of May 20, 2016, applicants who provide incomplete *Evidence of Insurability* or *Insurability Information Request* forms will have 14 days to respond from the date of our letter, which tells them what extra information we need. When we require a paramedical exam and when we request copies of medical records, members will have 30 days to respond.

Changing coverage

You are responsible for notifying Anthem about any change in an employee's status that would result in a change in coverage levels. For example, if your group offers more than one level of life insurance and an employee experiences a change in job classification, salary or any other event that would cause an increase or decrease in benefits, you must inform us within 31 days by submitting a letter of request.

Effective date for changes in coverage

A change in coverage can be due to:

- The employee's change in class.
- A change in earnings (for benefits based on earnings).
- An employee or dependent's request for increased coverage.

If the change is due to a change in class or earnings, and would increase the coverage without exceeding the guaranteed issue limit, the change is effective on the first day of active work after you tell us about the change. If the employer waits more than 31 days after the change to tell us, or any change would exceed the guaranteed issue limit, increased coverage is effective on the first day of the month after the date we approve the increase.

Any decrease in coverage due to a change in class or earnings will become effective immediately on the date of the change. The first premium for coverage is not due until the first premium due date following the change after our Underwriting approval (if required).

If the change is due to an employee or dependent's request for an increased amount, underwriting is required and the change will become effective on the first day of the month after the date we approve the increase. The first premium for coverage will be due on the first premium due date after our Underwriting approval.[

Newborn children

When dependent life coverage is already in effect:

If the employee has dependent life coverage that is in effect on the date of birth, coverage will begin for the newborn child when he or she reaches age 15 days (unless stated otherwise in the group *Certificate*).

When the employee did not have any dependents before the newborn child:

If an employee didn't have an eligible dependent (spouse, domestic partner or child) before the newborn child (he or she did not have dependent life coverage), he or she must submit an application to add dependent life coverage within 31 days of birth. Then, coverage for the newborn will begin at age 15 days (unless stated differently in the *Certificate*). If the employee waits until after the first 31 days following birth to submit an application to add dependent life coverage, then the newborn will be treated as a late enrollee and the employee must submit an Insurability Information Request/Evidence of Insurability. Coverage will become effective on the first of the month following Underwriting approval. If an employee had an eligible dependent (spouse, domestic partner, or child) before the newborn child, but did not elect dependent life coverage before the time of birth, then the newborn is treated as a late enrollee and the employee must submit an *Insurability Information Request/Evidence of Insurability* form for the child. Coverage will become effective on the first of the month following Underwriting approval. Birth of a child does not entitle the employee to add dependent life coverage with no medical underwriting if the employee didn't elect dependent life coverage when he or she was first eligible for it.

Exceptions for dependents:

- Dependent coverage will not become effective before employee coverage.
- Dependent life coverage for a child will not become effective before the child is 15 days old (unless it's stated otherwise in the *Certificate*).
- For a dependent confined in a hospital on the day before the effective date, coverage will begin 15 days following the end of his or her medical confinement, except for a newborn.

Beneficiary designations

Life insurance coverage requires designating a beneficiary. The employee's designated beneficiary must be indicated on the appropriate form and in a manner approved by Anthem Blue Cross Life and Health Insurance Company. The employee can change the beneficiary at any time. For more details, see the chart in the *Actions and forms* section.

Any life insurance benefit payment made by Anthem Blue Cross Life and Health Insurance Company under the plan and/or policy and before we receive such notice willfully discharges our obligation for payment. If the beneficiary designation is unclear at the time a claim is filed, a beneficiary will be assigned according to state law.

Actions and forms

If there are any changes or important events in your employee's life that might affect enrollment or a change in benefits, you must request the change using the appropriate form. Please see below the different actions available to employers and which forms need to be used.

You may also request that forms be faxed or mailed to you by calling Customer Service at 1-800-552-2137 (life) or 1-800-232-0113 (disability).

Desired action	Form to use	Notes	Mail to
Change employee's name or beneficiary designation	*Life Enrollment/Beneficiary Designation*	The change won't be effective until we receive the form.	Anthem Blue Cross Life and Health Insurance Company Small Group Services P.O. Box 9062 Oxnard, CA 93031-9062
Claim death benefits	*Beneficiary Claim and Group Policyholder Statement*	You are responsible for submitting a life claim upon the death of an insured employee.	Anthem Blue Cross Life and Health Insurance Company Life Claims Service Center P.O. Box 105448 Atlanta, GA 30348-5448
Assign sole right of ownership	*Absolute Assignment*	The employee must complete and submit an *Absolute Assignment Form* to assign the sole right of ownership to named assignees, including privileges and rights to beneficiary designation.	Anthem Blue Cross Life and Health Insurance Company Life Claims Service Center P.O. Box 105448 Atlanta, GA 30348-5448
Claim benefits during a terminal illness	Form *#3365, Claim for Personal Accelerated Death Benefits* Form *#3364, Accelerated Death Benefits Physician Statement*	The employee completes #3365. The attending physician completes #3364.	Anthem Blue Cross Life and Health Insurance Company Life Claims Service Center P.O. Box 105448 Atlanta, GA 30348-5448
Claim benefits for dismemberment or loss of an eye	Form *#SM2288 4/09 Accidental Dismemberment or Loss of Sight Claim Form #WL2007*	You and the employee complete #SM2288. The employee's doctor completes #WL2007.	Anthem Blue Cross Life and Health Insurance Company Life Claims Service Center P.O. Box 105448 Atlanta, GA 30348-5448
Claim total disability benefits	Form *#WL2004 Total Disability Claim Form – Waiver of Premium*	You are responsible for notifying disabled employees about their right to waiver of premium benefits.	Anthem Blue Cross Life and Health Insurance Company Life Claims Service Center P.O. Box 105448 Atlanta, GA 30348-5448

Waiver of premiums

- If an employee becomes completely disabled before age 60 and remains totally and continuously disabled, Anthem Blue Cross Life and Health Insurance Company will pay the insured employee's beneficiary the applicable life insurance amount, upon the death of the insured, according to the schedule of benefits.
- The claim amount cannot exceed the amount of the insurance in force at the time the total disability began.
- To initiate this benefit, Anthem Blue Cross Life and Health Insurance Company must be notified within 12 months from the date of disability.

- If the disability has been continuous for at least nine months (and no more than 12 months have passed from the date of total disability), a *Total Disability Claim Form (#WL2004)* must be completed:
    - The employer must complete the policyholder section of the form and the employee must complete the insured section.
    - We must receive the form within 12 months of the last day the employee worked due to the disability.
- If a death occurs during the period of total disability, a claim must be submitted, whether or not the initial notification of disability was made.

POP, FSA and COBRA administration

Section 125 premium only plan (POP)

Offered by WageWorks, Inc.

To apply for a Section 125 premium-only plan, you must submit a completed POP application along with a separate enrollment check made payable to Anthem (if applicable). POP allows employees to contribute their share of premiums on a pre-tax basis and provides you with certain tax advantages. The form is part of the Anthem *Employer's Guide to POP* or you can request one from your Anthem agent or Customer Service.

FSA and COBRA administration

Flexible spending account (FSA) administration services

WageWorks FSAs are designed to help maximize pretax dollars and reduce your payroll taxes. An FSA allows members to reserve a specific amount from their paychecks on a pretax basis each year to help pay for certain health and/or dependent care expenses that are not covered through your insurance plan. That amount is then placed in a special account that can be used to pay for those expenses throughout the year. Expenses for day care, prescription drugs and braces for children are examples of expenses that may be eligible under an FSA. Your tax savings may even offset the entire cost of FSA administration.

When you sign up for an FSA, a POP plan is automatically included.

COBRA administration services

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

Enrollment in FSA or COBRA services

For more information or to request an application for FSA or COBRA administration services, please call WageWorks directly at 1-800-876-7548. Anthem will not be involved in the enrollment or administration of WageWorks FSA or COBRA services. All applications will be sent directly to WageWorks, which will be your contact for any account concerns.

Forms and supplies

Downloading, requesting and ordering forms

We provide the forms and brochures you need to administer your group plan. Forms are available at no charge through several sources:

- Go online — View and print forms from our website at anthem.com/easyrenew.
- Call Customer Service — Forms can be faxed or mailed to you (including large-quantity orders) by calling Customer Service at 1-855-854-1429.

Together, we make a real difference!

We want to thank you, again, for trusting us with the health of your employees. We know that offering health coverage is a big and very important decision for your business. This valuable coverage is one we're committed to in every way – from helping your employees get and stay healthy to helping you, and them, save as much as possible through lower cost plan and care options. If you ever have any questions, please feel free to call us at 1-855-854-1429.

Our mission is to improve the lives of the people we serve and the health of our communities. And it's great that we can do this together!

Anthem BlueCross

Health · Pharmacy · Dental · Vision · Life · Disability

Anthem Blue Cross
Small Group Services
P.O. Box 9062
Oxnard, CA 93031-9062

anthem.com/ca
anthem.com/specialty

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