2017
Group Administrator Manual

Small Group employers

EmployeeElect for groups with 1-100 employees

Anthem BlueCross

Health · Pharmacy · Dental · Vision · Life · Disability

43197CAEENABC Rev. 08/16

Anthem BlueCross

Health · Pharmacy · Dental · Vision · Life

Dear group administrator:

We're very excited to welcome you to Anthem. As you are administering your company's health plan this year, please know that we are here to help you understand your plan and give you any support you may need. This guide is designed to:

- Give you useful information when you need it.
- Help you and your employees navigate important life events.
- Make sense of rules and regulations about health care, including employer requirements as mandated by the Affordable Care Act (ACA).

Having access to the enrollment information you need is critical for your success. And it's one of our top priorities. Our website, anthem.com/ca, is a great place to get answers and save time. With EmployerAccess, you can manage your group billing, payments and health plan quickly and accurately in real time. We'll tell you more about our online resources inside.

This guide can answer many of your questions about enrollment, billing, membership changes and other important details. For more support, log in at anthem.com/ca or call Customer Service at 1-855-854-1429.

Our mission is to improve the lives of the people we serve and the health of our communities. We appreciate the opportunity to serve you.

Sincerely,

Colin Havert

Vice President & General Manager
Small Group and Key Accounts
Anthem Blue Cross

In the event of a discrepancy between this manual and the *Group Benefit Agreement*, the terms of the contract prevail. The guidelines in this manual are subject to change from time to time without prior notice.

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Continuation of Coverage

Life insurance

Workers' compensation/Integrated MediComp℠

POP, FSA and COBRA administration

Forms and supplies

We are here to help

Questions about …	Contact	Phone/fax	Address	Hours of operation *All hours are Monday through Friday, unless otherwise stated.*
Billing	Enrollment and Billing	Phone 1-855-854-1429 Fax 1-855-750-2227	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 small.group@anthem.com	Anthem Blue Cross 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	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 p.m. PT = live person 24/7 for interactive voice response (IVR), self-service
	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	Monday through Saturday, 7:30 a.m. - 11 p.m. ET Sunday, 11 a.m. - 8 p.m. ET
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	Express Scripts (Home delivery) P.O. Box 66558 St. Louis, MO 63166-6658 Express-scripts.com	24 hours a day, seven days a week
Coverage while traveling (out-of-state providers)	BlueCard®	Phone 1-800-810-2583 Website bcbs.com	n/a	24 hours a day, seven days a week
Section 125 Premium Only Plan (POP)	WageWorks wageworks.com	Phone 1-800-876-7548	n/a	8 a.m. - 5 p.m. CT
Workers' compensation/ underwriting/claims	EMPLOYERS®	Phone 1-888-682-6671	EMPLOYERS® P.O. Box 539004 Henderson, NV 89053	4:30 a.m. - 5:30 p.m. PT
Groups requesting reinstatements	Accounts Receivable	Phone 1-888-686-9807	n/a	8 a.m. - 4:30 p.m. PT

Go to anthem.com/ca for access 24 hours a day, seven days a week.
You can also reach us at small.group@anthem.com.

Check out these helpful self-service options

Internet

For comprehensive resources, please visit our website at **anthem.com/ca**, select **Members** or **Employers**, and then follow the prompts.

Employers

The *Employers* section of our website provides two levels of time-saving resources for group administrators.

Account access through EmployerAccess

With EmployerAccess, you have password-protected access to real-time information that makes it easy to manage your Anthem Blue Cross account. Our online registration is quick, easy and secure.
Then, you can log on to: employer1.anthem.com/wps/portal/eeaemployer.

Online enrollment

- Enroll new hires
- Manage open enrollment benefits
- 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
- See Find a Doctor tool to help employees locate a doctor, hospital or other health care provider

Life and disability tools (if applicable)

- Initiate a life or disability claim

Online billing

- Online: the Anthem standard for sending bills and receiving payment
- Convenience: saves money and time because you're already online
- Savings: improved control over cash flow – no waiting and wondering when checks will clear
- On-time easy access: ability to review, download and print account statements at your convenience – no waiting for the mail
- Security: supports fraud prevention – no checks get lost
- Pay your invoices
- View, print and download invoices
- Schedule recurring payments
- Manage bank accounts with privacy
- Manage billing emails

Other information

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

How can you submit electronic eligibility transactions with Anthem?

There are various ways to submit electronic enrollment using EmployerAccess Portal, 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:

- Less paperwork
- Member services will be more available
- Quicker to make changes and enrollments
- Creates audit trails of all changes
- Greater accuracy of data
- Monthly premium statements are more accurate

Sending eligibility electronically can be used for both initial enrollment and ongoing maintenance. For security purposes, we do request an initial lead time depending on what type of electronic enrollment is requested/used. For an initial enrollment, a complete roster of employees with their dependents and their selected coverage may be required. If you are interested in getting setup on a form of electronic enrollment, contact your Sales representative.

Materials and other documents

Our Small Group Easy Renew site has all of the applications, forms, rates, brochures and other materials you may need. However, Easy Renew can be used 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 our EmployerAccess site by selecting the **Forms** tab.

Please give us a call at 1-855-854-1429 to learn how EmployerAccess can streamline account administration for you.

Members

Private information is encrypted for security. It's only available by using a personal identification number (PIN). Members can securely:

- Update their personal information including their addresses.
- Review their plan coverage.
- Search for network doctors, specialists and hospitals.
- Change their primary care physician (PCP).

Check their claims statuses.

Interactive voice response system

Our interactive voice response (IVR) system guides callers to a customer service representative or automated self-service options through a series of instructions and prompts. The system includes voice recognition enhancements to guide callers based on their verbal responses. Touch-tone response features 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.

Welcome to Anthem

Prompt	Response
Are you a ... • Group administrator? • Broker? • Sales agent? • Member?	Push one 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.

Group requirements

Accurate information

For us to effectively administer your group's benefits, you must submit timely, accurate information related to eligibility changes. This includes notifying us about new employee or dependent additions, changes in plans, terminations, address changes, leaves of absence, COBRA and Cal-COBRA notices, Medicare eligibility and individuals turning 65. You must also notify us about changes that affect your group. These changes include, but are not limited to, an address change, a change of company waiting period, a change in company ownership, a change in group administrator, an acquisition or merger of or by another company or business entity and a change in the number of persons employed by the company when such a change may affect your group's COBRA, Cal-COBRA or Medicare payee status. You must submit information about these and other events.

Failure to provide 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 with an average of at least one, but no more than 100 full-time, 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 recently adopted the federal method for counting full-time employees and full-time equivalent employees.[1]

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 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 (2015) starting in 2016. It is not intended as legal or financial advice or opinion. Persons seeking specific guidance concerning the Affordable Care Act, the Internal Revenue Code or California State laws or regulations should consult with their attorney, certified public accountant or other authorized consultant or advisor. These contents should not be construed as or relied upon for legal or tax advice in any particular circumstance or fact 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.
  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.
  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 (or example, Large Group or Small Group).

Employee participation requirements

A certain percentage of employees must enroll in the Anthem coverage you're offering.

To calculate employee participation, start with the total number of eligible employees, including the company's owners. Next, subtract the number of employees with allowable waivers (for example, employees with Medicare/Medi-Cal/ military and those covered as dependents on a spouse's or parent's employer-sponsored group plan). The result is the total number of eligible employees. Then subtract the number of employees who aren't participating for other reasons (for example, employees who want to remain on an existing Individual plan, or who are covered through the exchange, or who simply choose not to participate). Now you have the total number of eligible enrolling employees. Finally, divide the number of eligible enrolling employees by the number of eligible employees. The resulting percentage indicates your group's participation. (See the next page for an illustration of how to calculate employee participation.)

Example 1 of 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 of group NOT meeting participation:

Total number of employees:	10
Invalid waivers (1 exchange, 1 Individual, 2 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%

Medical participation requirements for 1–100 employee Small Groups

A Small Group must have at least one eligible employee. A sole proprietorship, partnership or qualified joint venture (such as, husband and wife/domestic partners are co-owners of the business and file 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.

The following are 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

The group participation requirements are:

- 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 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 2-100 you may choose 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 two employees must enroll:

- 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.
- Dual Option (employer can select two plans to offer to employees) is available for groups with at least 10 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.)

Medical participation requirements for 1–100 employee Small Groups (continued)

Dental Complete PPO Classic and Enhanced plans:

- 2–4 eligible employees groups: 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.
- 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 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.)

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

- A minimum of five 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 five employees must enroll in each plan. (You may choose one voluntary Dental Net DHMO plan and one voluntary Dental Complete PPO plan.)

1 Subject to regulatory review and approval.

Vision participation

Employer-sponsored:

- 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
- Employer-sponsored plans available for 2–100 Employee Small Groups must have a minimum of 10 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:

- Voluntary vision plans available for 2–100 employee Small Groups must have a minimum of 10 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

Basic Life & Accidental death & dismemberment, Short Term Disability:

- A minimum of two Employees must enroll
- 75% participation
- 100% participation for noncontributory plans

Basic Dependent Life:

- A minimum of two Employees must enroll
- 100% participation for noncontributory plans

Short Term Disability: 10-100 eligible employees:

- 75% participation required on contributory plans
- 100% participation for noncontributory plans

Long Term Disability: 10-100 eligible employees:

- 100% participation required for contributory plans
- 75% participation required on contributory plans
- 100% participation for noncontributory plans

Optional/Voluntary Life/Accidental Death & Dismemberment:

The greater of five enrolled employees or 20% participation required.

Voluntary Short Term Disability and Voluntary Long Term Disability:

The greater of 10 enrolled employees or 20% participation required.

Anthem may conduct periodic audits to confirm participation levels.

You must maintain the corresponding minimum participation levels in order to remain eligible. You are subject to cancellation or nonrenewal if participation falls below the required minimum.

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 purchase 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

Contribution

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

Traditional option — A minimum contribution of 50% of each covered employee's monthly health premium for EmployeeElect.

or

Fixed-dollar option — Any fixed-dollar amount of $100 or greater (in $5 increments) of each covered employee's health premium for EmployeeElect.

or

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, contribution requirements will not be enforced.

Dental

Traditional option — A minimum of 50% of each covered employee's monthly dental premium is required.

Voluntary dental — A minimum of 0% and a maximum of 49% of each covered employee's monthly voluntary dental premium. Voluntary dental plans may be 100% employee-paid and cannot be combined with nonvoluntary Small Group dental plans.

Dental (Anthem Dental Prime and Complete) — Employer-sponsored plans require employers to contribute between 50% and 100%.

Vision

Employer-sponsored plans require contributions added to match UW guide between 50% and 100%.

Voluntary vision

A minimum of 0% and a maximum of 49% of each covered employee's premium; voluntary vision may be 100% employee-paid. Cannot be combined with nonvoluntary Small Group vision plans.

Life

You must contribute a minimum of 25% of each covered employee's monthly life premium. Payroll deduction is required, if contributory.

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 chose one wait 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

Contract 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" below to determine when each type of benefit modification may be requested and which documents must accompany your request.

The following criteria also apply to group-level contract benefit modifications:

- Adding or downgrading a medical plan will only be allowed at the group's anniversary.
- Anniversary month changes will be allowed once in a 12-month period, subject to Anthem approval. Change in plan or network will constitute a new rate and benefit guaranteed period.
- Increases in life benefits may be subject to Underwriting approval.
- Changes in products, portfolios or programs do not constitute a new rate and benefit guarantee period.
- The rate guarantee for dental and/or vision coverage that is added to an existing medical policy will default to the medical rate guarantee after the initial rate guarantee is exhausted. No rate guarantee will be applied to life policies added to an existing medical policy.
- Existing groups can only change their employer contribution once in a 12-month period, subject to approval.
- Anthem must be notified of changes in company name, ownership or tax ID number. These changes are subject to review.

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 level:

Covered subscribers may move to a different product offered by their group at the anniversary month of the group's original effective date. 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.

General underwriting guidelines for existing business

Benefit modification job aid

Benefit modification	When eligible	Documents necessary
Add or downgrade a medical plan	At a group's anniversary only	1. Letter/email from the group signed by owner/officer or renewal documents, if available 2. *Employee Applications* for any new enrollments who are not currently enrolled, or renewal documents, if available
Change anniversary month Change in plans or networks	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.
Add Dental Net (DHMO) for 2-100 (A minimum of two 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 Applications* for any new enrollments who are not currently enrolled, or renewal documents, if available 3. Dental Net (DHMO) office numbers
Add Dental Complete PPO plans for 2-100 (A minimum of two 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 Applications* for any new enrollments who are not currently enrolled, or renewal documents, if available 4. A copy of the Agent quote: brokerportal.anthem.com/ehb/web/bkr/acc/login.htm

General underwriting guidelines for existing business

Benefit modification	When eligible	Documents necessary
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: 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 documentation	1. Letter/email from the group signed by owner/officer 2. New *Employer Application* 3. *Employee Applications* for any new enrollments who are not currently enrolled, or renewal documents, if available 4. Agent Small Group Quote 5. SIC code required
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 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, including contribution amount 2. *Employee Applications* for any new enrollments who are not currently enrolled, or renewal documents, if available 3. Copy of Agent quote: 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 Applications* for any new enrollments who are not currently enrolled, or renewal documents, if available 3. SIC code required
Add employee life insurance or increase existing coverage The following amounts are guaranteed issue (GI): $30,000 for 2-9 enrolled $100,000 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 Applications* for any new enrollments who are not currently enrolled, or renewal documents, if available 4. Evidence of Insurability for any amount over guaranteed issue 5. SIC code required 6. Copy of Agent quote: 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:** $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 **Note**: Dependent child coverage is applicable for ages 6 months 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 Applications* for any new enrollments who are not currently enrolled, or renewal documents, if available 4. Copy of Agent quote: 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: 20% of total or 10, whichever is greater) **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)	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 Applications* for any new enrollments who are not currently enrolled, or renewal documents, if available 4. Copy of Agent quote: brokerportal.anthem.com/ehb/web/bkr/acc/login.htm
Add part-time employee eligibility	First of the month following receipt of all 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.
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 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 Applications* for those enrolling in the new entity 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.

General underwriting guidelines for existing business

Benefit modification	When eligible	Documents necessary
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 Applications* for all new employees enrolling or declining 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.
Acquisition If a company insured with Anthem is acquiring another company also 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 Applications* for all new employees enrolling or waiving coverage 6. Prior carrier bill from acquired company **Note**: Additional documentation and review may be required.
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 Applications* for all new employees enrolling or waiving coverage 6. Prior carrier bill from acquired company **Note**: Additional documentation and review may be required.
Add Workers' Compensation plan	First of the month following receipt of all documentation	Contact Employers Workers' Compensation Insurance Specialists at 1-888-682-6671.

Maintenance

ID cards and certificates

All enrolled employees will receive employee *Certificates* and/or a *Combined Evidence of Coverage and Disclosure Form* (EOCs) and Anthem Blue Cross member ID cards. However, if you have elected to access electronic copies of EOCs, you and your employees will have to register at EmployerAccess or at anthem.com/ca to view them. Please be aware that you will also need to make printed copies available to your employees upon request.

Additional cards can be ordered through our Membership department. Replacements for ID cards that are lost or destroyed can be ordered online (EmployerAccess), by calling Customer Service or the member can request one at anthem.com/ca.

Anniversary dates

Your anniversary date is the month and day your policy became effective and coverage started. **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).

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

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 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. You must notify us about this type of change in a timely manner. Please submit these changes on a *1-100 Small Group Information Change Form*. Once coverage ends, the employee may have the option to continue coverage under COBRA or Cal-COBRA benefits (see "Continuation of coverage" in the *Group requirements and maintenance* section). See page 25 for definitions of eligible employees (full-time and part-time).

Changes in ownership

You must notify us in writing about any changes in the company's ownership. The written notice must contain full details, including a copy of the buyout agreement, sale of assets agreement or other agreement that resulted in the change. Continued coverage for your group as a result of these changes is subject to Underwriting review and approval. If the new owner chooses to join the plan, a new Underwriting review may be required, which could affect premium rates. Anthem also must be notified if the name of the company or its federal tax ID number changes. 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 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, 2017	April 1, 2017
Request received	April 25, 2017	May 6, 2017
Effective date	April 1, 2017	May 1, 2017

Cancel/nonrenewal of coverage

We reserve the right to cancel/not renew group coverage for reasons including, but not limited to:

- 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 may 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.

The employer is 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. Please see page titled "We are here to help" 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 Financial Responsibility Act (TEFRA) and the Deficit Reduction Act (DEFRA) requirements, an Anthem health 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, we are the secondary payer to Medicare and do 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. We are 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	Blue Cross
• Employer has less than 20 employees	Medicare
Under 65, Medicare disabled	
• Employer has 100 or more employees	Blue Cross
• Employer has less than 100 employees	Medicare
ESRD (permanent kidney failure), any age, any size employer	
• First 30 months after Medicare eligibility	Blue Cross
• After 30 months	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 nonduplicate 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 policy only applies if they are enrolled in that part of Medicare.

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

Value-added services for members

At Anthem, we understand that the health of your employees has a great impact on the health of your business. That's why we provide a unique blend of health and wellness programs to help keep all of your employees at their healthy best, no matter how healthy they are or need to be. Our health and wellness programs include:

- Care management
- ConditionCare
- 24/7 NurseLine
- Future Moms
- Healthy Lifestyles and more

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® 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 significant savings — to doctors and hospitals outside California that participate in other Blue Cross plan networks. The program gives members access to more than 91% of doctors and 96% of hospitals in the United States. In addition to cost savings, BlueCard offers the security of access to quality health care, wherever our PPO members travel in the United States.

To locate a BlueCard participating provider, members can call **1-800-810-BLUE (2583)**.

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 physical 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.

Premium payments

Beginning May 1, 2016, online payment is the new standard for Anthem Blue Cross Small Groups.

We know that conducting business quickly, accurately and securely is important to you. And to support your business, you need to know about important billing and payment changes coming soon.

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 online and receive payments online through our EmployerAccess portal (employer1.anthem.com/wps/portal/eeaemployer). The group will receive an itemized monthly invoice from Anthem Blue Cross approximately one month before the invoice due date. The invoice 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 the electronic billing and payment process.

What you need to know

When your group is signed up for online group billing, we will send you a notification email that your group invoice 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!

The group will receive an itemized monthly invoice from us approximately one month before the invoice due date. The invoice will include the due date, total premium due, past due amounts, ACA fees and any other applicable fees.

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 the NEW, super-fast, free self-service option to submit a single premium payment** when you don't have time to log in to Employer Access. You simply make your payment as a GUEST user. All you need is a valid tax ID and case or group number to get started. Visit https://easypay.anthem.com today.
2. **EmployerAccess** is a great way to pay your premiums online. Log in to EmployerAccess (accessible via our Employer Portal) and set up your ePayments on the "*billing*" tab using these easy instructions. 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 online premium payments. By registering for EmployerAccess, you can make a payment or schedule future payments. For details, go to employer1.anthem.com/wps/portal/eeaemployer 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 the steps listed below.

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

Please note: This is a "lock-box" arrangement, which means that checks are automatically deposited. Depositing your 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 fie. There will be $10 fee for payments made by phone.

Please make sure to check that each monthly invoice 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 invoice is paid each month. Separate checks for each of the group's Anthem Blue Cross products are not required.

Adjustments to your invoice — employee/dependent additions and deletions

It's important to pay the premium amount listed on your monthly invoice. Please do not include premiums for new employees who are being added to the group or who do not appear on the invoice. These premiums will be included on a later invoice, after they've been processed and applications are approved. If you are mailing your payment, please do not 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 the chart on page 5 for the fax number for submitting applications.)

Please do not 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 recommend that you submit deletions to us as they occur for timely processing. 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 be reflected on your next scheduled billing statement after we have processed the deletions. Please see "COBRA billing" on page 36 for the employer's responsibility on submitting COBRA premium payments.

Please do not submit terminations with your premium payment. Terminations may not be processed because they will go to the premium payment lock-box, not directly to Anthem. Instead, please send terminations to the fax number shown on your billing statement. Failing to pay the premium or submitting membership changes by marking the invoice, does not meet the notification requirements for terminating an employee or dependent from the policy. To submit member changes, visit anthem.com/easyrenew and process those using EmployerAccess, our online plan administration system.

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:

- **Phone payment fee (for pay-by-check only)**
  We charge $10 for this service.
- **Reinstatement fee**
  If the policy is canceled for not complying with the contract, and the 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.

1 Administrative fees are subject to change.

Nonpayment of premiums due

We reserve the right to end your Small Group policy for nonpayment. If you do not remit your payment on time, your Small Group 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.[1] Because 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. Please see "Canceling group coverage" in the *Group requirements and maintenance* section 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 invoice, or it will be considered late. The group 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.

1 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 policy for grace period details. Reinstatement is at the absolute and sole discretion of Anthem Blue Cross and reinstatement fees will apply. If reinstatement is approved, you will be required to sign up for automatic reccurring payments through EmployerAccess. Exceptions must be approved by Anthem.

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

Enrollment guidelines

Eligible employees:

a. 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.

b. 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.

c. Permanent employees who work at least 20 hours, but not more than 29 hours, 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 who live outside 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 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:

a. Lawful spouse

b. Registered domestic partner (Family Code Section 297)

c. 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 physician of the child's condition.

d. 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 persons are not related by blood in a way that would prevent them from being married to each other in this state.
- Both persons are at least 18 years of age.
- Either of the following:
  - Both persons are members of the same sex except as provided in section 291.1.
  - One or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership, unless one or both of the persons are over the age of 62.
  - Both persons 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. Please see the *Over-age dependents* section 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 days 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*
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.

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

Enrolling new employees

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 on the next page.) There are **no exceptions** to these requirements. Incomplete applications will not be processed, which may delay the employee's coverage effective date. If we get an application more than 45 days after the employee's eligibility date, the employee will be considered a late enrollee and would not be eligible for coverage until the next open enrollment period without a qualifying event. (See "Late enrollees/open enrollment" in the *enrollment guidelines* section.)

The employer must make sure that sections A and F of the *Employee Enrollment Application* are completed or that the *Employee Waiver Form* is submitted for any employees and/or eligible dependents who waive coverage.

We recommend submitting an application immediately after hiring an eligible employee. Coverage will not begin before the group-imposed waiting period is over.

You can also enroll a new employee (and dependents if applicable) online. Please see "Internet" in the *Self-service options page* for more information.

Please make sure that an application for each eligible employee who is applying for or waiving coverage is sent to us within 45 days of the eligibility date. Failure to do so will delay coverage, which may expose you to liability to the employee and Anthem. Remember, eligible employees can be enrolled online through EmployerAccess.

If you aren't registered yet 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).

Incomplete applications will be returned, which will delay the coverage effective date.

Coverage effective dates

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

- The date of hire
- An employer-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 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 will 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*.

Coverage effective dates (continued)

Examples of effective dates for eligible employees:
(Group's waiting period is the first of the month following one month.)

	Example 1 Employee submits application within time frame	**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 month after hire date
Hire date	April 10, 2017	April 10, 2017	April 10, 2017	April 1, 2017
Eligibility date	June 1, 2017	June 1, 2017	June 1, 2017	May 1, 2017
Completed application received	June 15, 2017	July 1, 2017	August 1, 2017	April 15, 2017
Effective date	June 1, 2017	June 1, 2017	Group's next anniversary or approved qualifying event	May 1, 2017

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 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 the "Enrolling new employees" subsection). 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 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, 2017, it can submit February 1, 2017, through April 30, 2017.

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 who 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

Submit all completed *Employee Enrollment Applications* to:

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

Fax: 1-855-750-2227

Or enroll members online with EmployerAccess at **anthem.com/ca**.

Enrollment actions guide

Action	How this action can be done:										Comments
	Electronic enrollment[1,2]				Paper						
	EmployerAccess Portal	Census Enrollment tool	Electronic file (834)	Real time	Internet EmployerAccess	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	x	x	x	x	x		x				Additional documentation may be needed, depending on the type of dependent.
Add dependents for an **existing** employee	x	x	x	x	x		x		x		Can use either *Employee Enrollment Application* or *Employee Change Form*.
Waive coverage for an employee and/or dependents	x			x	x		x		x	x	*Employee Enrollment Application, Employee Change Form* or *Employee Waiver Form* must be completed.
Change plans for employees or dependents who already have coverage	x	x	x	x	x		x		x		Changes can only be requested on the group's anniversary date.
Terminate an employee and/or dependents from the plan	x	x	x	x	x			x			Notify Anthem Blue Cross immediately upon termination.
Discontinue coverage for employees and/or dependents who still remain eligible under the plan	x	x	x	x	x		x	x	x	x	If you use a *1-100 Small Group Information Change Form* you must also complete the waiver section of the *Employee Enrollment Application* or complete the *Employee Waiver Form*.
Change an employee's address	x	x	x	x	x		x	x	x		The employee can also call Customer Service directly to make this change.
Notify us about a COBRA or Cal-COBRA qualifying event for an employee and/or dependents already enrolled in the plan	x	x	x	x	x			x			Complete the *1-100 Small Group Information Change Form* or the *Employee Change Form*.
Remove a subscriber from federal COBRA	x				x			x			Complete the *1-100 Small Group Information Change Form*.
Change the employer's address (This may affect the employee's rate.)	x				x	x		x			You can also submit a written request on your letterhead, signed by an owner/officer of the company.

Important note about Internet capabilities: For your protection, registration in EmployerAccess for Small Group employers is required to perform some of the online functions marked above in the Internet column. Registration is quick and easy and provides convenient, password-protected access for administering your group account. See the *How to get help* section for details.

1. Please refer to: Electronic submission of enrollment guidelines on pg 31.
2. Please contact your local Sales representative should you have further questions on getting started on Electronic Enrollment or refer to the "Contacts" section of this guide.

Electronic submission of enrollment and eligibility data

- 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" section

When medical benefits become active

See "Employer Waiting Periods" section

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 Blue Cross *enrollment forms*. Please refer to the last page.

Membership changes

Deleting employees from the plan

Please complete section 2 of the *1-100 Small Group Information Change Form* for the following:

- Employment is terminated.
- An eligible full-time employee changes to part time, and your plan does not cover part-time employees.
- An employee is on a leave of absence (health and/or personal) and the time period that you cover 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 employee becomes ineligible due to becoming seasonal, temporary, substitute or 1099.
- An employee otherwise becomes ineligible to participate in the plan.
- The employee no longer wants to continue federal Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage.

Please include the following information:

- Employee name
- Social Security number or 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
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. Deletion of the terminated employee's coverage will be effective as of the last day of the month in which we receive notification of the termination. 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 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.

Deleting employees who remain eligible but discontinue coverage

Please complete section 2 of the *1-100 Small Group Information Change Form* and Complete sections A and F of the *Employee Enrollment Application* or the *Employee Waiver Form*.

All employees and/or eligible dependents who previously waived coverage and now want to enroll must complete an Employee 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, 2017	April 3, 2017
Requested employee cancellation	May 1, 2017	May 1, 2017
Request to cancel received	April 1, 2017	June 15, 2017
Effective date of cancellation	May 1, 2017	June 1, 2017

- Employees who worked on the first of the month will not be taken off the 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 aged 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* (EOCs) 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 terminates, the member is totally disabled and certain other criteria are met. The extension (up to 12 months) covers only the totally disabling condition and is subject to review every three months. An extension of benefits must be requested in writing or by calling our Customer Service department within 90 days of the cancellation of coverage (see "Continuation of coverage" in the *Group requirements and maintenance* section).

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 on the subscriber for support and maintenance: 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.

Summary of Benefits and Coverage (SBC)

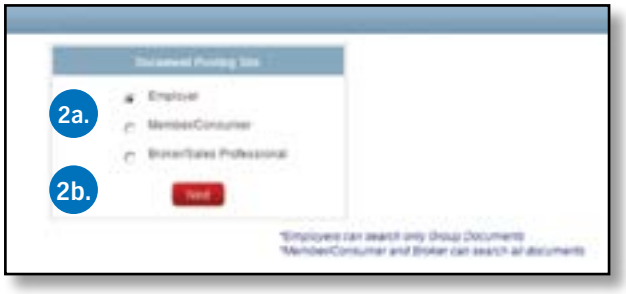
The Affordable Care Act (ACA) requires that all members of fully insured medical plans receive an SBC. Groups are responsible for sending an electronic or printed copy of the SBC to participants and beneficiaries. SBCs can be accessed at sbc.anthem.com. The diagram on the next page shows you how.

How to get a *Summary of Benefits and Coverage* for your standard fully insured benefit plan effective January 1, 2017

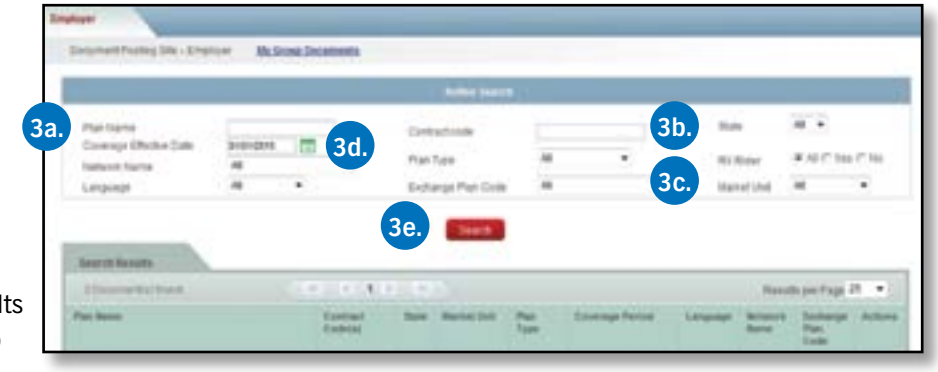
Anthem BlueCross

Employers are responsible for sending an electronic or printed copy of the *Summary of Benefits and Coverage* (also called an "SBC") to plan participants and beneficiaries. Here's how you to get the SBC for your Small Group fully insured plan:

1. Go to **sbc.anthem.com**.
2. Start by:
   a. Selecting your status.
   b. Select **Next**.



3. Plans are found by looking at various data elements. This is our recommendation:
   a. Plan Name (full or partial).
   b. State.
   c. Market (for example Small Group).
   d. Appropriate coverage effective date.
   e. Select **Search**.



The more descriptive you are, the fewer results will be returned. Enter a partial plan name to view more plan options. Or eliminate data elements to broaden the search.

For example, enter any key word or phrase: Entering "Anthem Platinum Select PPO" will return any plan match with "Anthem Platinum Select PPO" in the name.

4. Select the plan by selecting the down arrow icon.
5. The SBCs will be distributed based upon the information provided (screen will be different based on status selected). Select **View**.
6. Select **Save** on the pop-up box. Save to the desired location on your computer.

7. Open from the location on your computer (screenshot not shown), and print or attach to an email (if electronic distribution criteria are met) to distribute the SBC.

Please make sure you are using the most updated Internet browser.

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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.

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. For your convenience, you can contact our Customer Service department for the **Cal-COBRA, COBRA and Medicare survey.**

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 one 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
- 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 premium 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. 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 policy. No lapse in coverage may occur, so 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 invoice. The employer will not be charged the Cal-COBRA premiums.

A 10% administrative fee will be charged.

COBRA

Participation in the employee's benefit plan, as well as coverage under whatever 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 is not responsible for COBRA administration. (See page 41 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 must complete section 2 of the *1-100 Small Group Employee Information Change Form* to notify 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, Anthem will reinstate employee and/or dependent coverage retroactive to the original employment or coverage termination date, without a lapse in coverage.

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 "noncreditable" coverage notice to their employees. This notice is for all of the Medicare beneficiaries about their 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 your 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 "noncreditable" 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 you to notify the Centers for Medicare and Medicaid Services (CMS) about the creditable/noncreditable nature of the prescription drug coverage you provide to your 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 Blue Cross and its affiliated companies have been chosen as a provider of Medicare Part D plan options. The list of plans which are "creditable" or "noncreditable" are available through EmployerAccess. 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-MEDICARE. TTY users can call 1-877-486-2048, 24 hours a day, seven days a week.

Deleting 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

If a dependent becomes eligible for COBRA, please complete section 2 of the *1-100 Small Group Information Change Form* and submit it to us. A dependent is eligible 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.

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. 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

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 invoice (see the About your billing section).

Do not adjust your invoice 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 invoice.

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 policy.

Enrolling new employees

An *Employee Enrollment Application* must be submitted to enroll a new employee in life insurance (see "Coverage effective dates" in the *Enrollment guidelines* section 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 ends, 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 then satisfy medical evidence underwriting; 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.

Starting 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 additional 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 us 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 (so 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. 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 using the *Beneficiary Change form*. Any life insurance benefit payment made by Anthem Blue Cross Life and Health Insurance Company under the 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

You can view or print forms from our website at **anthem.com/ca**. You may also request that forms be faxed or mailed to you by calling Customer Service at **1-855-854-1429**.

Desired action	Form to use	Notes	Mail to:
Change employee's name or beneficiary designation	*Life Enrollment/Beneficiary Designation*	The change will not 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.	
Claim benefits during a terminal illness	Form #3365, *Claim for Personal Accelerated Death Benefits* Form #3364, *Accelerated De*ath Benefits Physician Statement	The employee completes. The attending physician completes.	
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.	
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.	

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 the disability.
- If the disability has been continuous for at least nine months (and no more than 12 months has passed from the date of total disability), a Total Disability Claim Form (#WL2004) must be completed:
  - You 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.

Workers' compensation/Integrated MediComp℠

Offered by EMPLOYERS®

Anthem Blue Cross and EMPLOYERS are working together to offer a convenient, cost-saving option for integrated billing. By combining Anthem Blue Cross Small Group medical coverage with workers' compensation insurance offered by EMPLOYERS, policyholders can benefit from a premium discount, a monthly combined bill, a monthly payment plan and a network of physicians.

Please see the About your billing section to learn about submitting your workers' compensation payment. For more information, talk with your Anthem Blue Cross agent or call 1-855-854-1429.

Please note that EMPLOYERS workers' compensation policies and Anthem Blue Cross/Anthem Life health, dental, vision and life policies may have different grace periods. Please refer to your policy's grace period to avoid a service interruption.

How to cancel coverage

Please fax cancellation requests to **1-702-837-3111**, email them to **westunderwriting@employers.com** or mail written requests to:

EMPLOYERS
P.O. Box 539125
Henderson, NV 89053

Integrated MediComp savings

All EMPLOYERS workers' compensation accounts written through our California office are eligible to be integrated.

Policies effective June 1, 2014, and later will be offered through Employers Compensation Insurance Company, Employers Preferred Insurance Company and Employers Assurance Company.

Claims kit

With EMPLOYERS workers' compensation coverage, you'll receive a claims kit in a mailing separate from your policy that contains the forms you need to comply with state requirements for employer handling and reporting of workers' compensation claims and injuries. These forms include:

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

To report a claim, please call the EMPLOYERS 24-hour, toll-free claims reporting service at **1-888-682-6671**, or fax your claim to 1-877-329-2954. You may also mail it to:

EMPLOYERS
P.O. Box 539004
Henderson, NV 89053

Health treatment and network kit

When you receive your claims kit, you will also receive the resource materials you need for directing injured employees to the appropriate health network facilities. Arrangements will be made with Anthem Blue Cross through CaliforniaCare, Prudent Buyer and their workers' compensation subsets that are available to you.

Claims kits are only sent with the initial policy. If a new claims kit or additional kits are needed, please call EMPLOYERS at **1-888-682-6671 or email reorderforms@employers.com**.

Mandated forms

Posting Notice

You must display a posting notice where it can be seen by all employees at each of your business locations. Your policy expiration date must be included on the notices. Also include fire, police, doctor and hospital emergency numbers on the notices.

Facts About Workers' Compensation

This pamphlet, designed for your employees, explains workers' compensation benefits, including who's covered, what is covered and how to report an injury, along with a contact for more information. In addition to placing this pamphlet beside the posting notice, the law requires that you provide it to every new employee at the time of hiring or by the end of the first pay period.

Información Acerca de la Compensación de Trabajadores

This is the Spanish version of the *Facts About Workers' Compensation* pamphlet.

Facts for Injured Workers

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

Información Para Trabajadores Lesionados
This is the Spanish version of the *Facts for Injured Workers* pamphlet.

Employee claims for workers' compensation benefits (DWC-1)

California law requires the following:

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

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

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

Step 4: You must promptly forward the "insurer copy" to EMPLOYERS. The California Labor Code has various penalties or fines, including for failure to notice a delay or make payment of benefits within 14 days of the date of knowledge of the injury.

Prompt reporting is essential to prompt disability payment. We strongly recommend that you call the EMPLOYERS 24-hour claims reporting service at **1-888-682-6671** to report all injuries. If the claim is reported by telephone to this number, it is not necessary to complete the EMPLOYERS *First Report of Injury* (form #5020) unless you wish to do so. EMPLOYERS will give you written confirmation of receipt of your telephone report, as well as a completed #5020 form, by fax or mail.

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 Blue Cross (if applicable). POP allows employees to contribute their share of premiums on a pretax basis and provides you with certain tax advantages. The form is part of the Anthem Blue Cross *Employer's Guide to POP* or you can request one from your Anthem Blue Cross agent or Customer Service.

FSA and COBRA administration

Flexible spending account (FSA) administration services

WageWorks, Inc. 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 Blue Cross 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**.

To maintain adequate inventories, we appreciate receiving your orders 30 days before the date you need the delivery. We recommend that you request three-month supplies.

Please keep in mind that our forms are updated from time to time. Check online occasionally for the most recent revisions and replace outdated stock. Submitting outdated forms may delay your requests.

Form	Form number
Conditions of Enrollment/Start-Up Companies/PEO Spin-Off Groups	*12378CAEENABC*
Employer Application	*38400CAEENABC*
Employee Application	*37612CAMENABC*
Employee Waiver Form	*20533CAMENABC*
Employee Change Form	*41759CAMENABC*
Electronic Debit Payment form	*58163CAEENABC*
Eligibility Statement	*12252CAEENABC*
Statement of Accountability/Translator form	*54046CABENABC*
Member Social Security Number Exceptions Request form	*28645CAMENABC*
Agent Checklist	*43043CABENABC*
Guaranteed Association Attestation	*44723CAEENABC*
Contract Code List	*45639CABENABC*
Anniversary Month Change form	*50211CAEENABC*
Plan Change Request form	*37640CAEENABC*

This group administration manual is intended to be a brief outline of benefits available. It does not include all of the terms of coverage offered by Anthem or its affiliates.

The entire terms are contained in the respective contract documents (the applicable certificate, policy, employer application and/or trust agreement) for each line of coverage. In the event of a conflict between this manual and the policy under which the group insurance coverage is provided, the terms of the policy will prevail. The guidelines in this manual are subject to change from time to time without prior notice. Products may vary, and may not be available in all states. This information describes Anthem's standard programs. Other options may be available upon request to and approval by Anthem. Exclusions and limitations are listed in the product brochures for these products.

NOTES

NOTES

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