

Group Administrator Manual

Small Group Employers
EmployeeElect



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Thank you for choosing Anthem Blue Cross

HEALTH | DENTAL | VISION | LIFE

October 2010

Dear Group Administrator:

Thank you for choosing Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company to provide health care coverage for your employees and their families. We appreciate your business and look forward to a long-lasting relationship with you, our valued customer.

Your satisfaction is our primary concern, so we designed this *Group Administrator Manual* to help you with questions about enrollment, billing, membership changes and other day-to-day administrative activities. You'll also find helpful resources online at anthem.com/ca. Additionally, our Customer Service representatives are here to support you. Just call us toll free at 800-627-8797.

Welcome to Anthem Blue Cross, where 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,

A handwritten signature in black ink, appearing to read "Mark Morgan", is written over a light gray rectangular background.

Mark Morgan
Vice President and General Manager

Table of Contents

How to get help

Customer Service contact information	1
Self-service (online or using our Interactive Voice Response system).....	2

About your billing

Premium rates (including the standard employee risk rate and risk adjustment factor).....	3
Billing cycle	3
Premium payments (including adjustments to your bill and where to mail payments)	3
Administrative fees (for phone payments, reinstatement, returned checks and late payments).....	5

Enrollment guidelines

Eligible employees (definitions of <i>full time</i> , <i>part time</i> , <i>sole proprietor</i> , etc.).....	6
Employees living outside California.....	6
Ineligible employees.....	6
Enrolling new employees.....	7
Coverage effective dates	7
Enrolling rehired employees.....	8
Eligible dependents (including definitions and age and qualification criteria for children).....	9
Enrolling eligible dependents (including application requirements and timing).....	11
Declinations.....	12
Late enrollees/open enrollment.....	12
Pre-existing conditions.....	12
Where to submit applications	12
Employee application tips.....	13
Enrollment actions guide (“how to” chart for frequent functions).....	13

Membership changes

Deleting employees from the plan	14
Deleting terminated employees.....	14
Deleting employees who remain eligible but discontinue coverage	14
Deleting COBRA members	15
COBRA-eligible dependents.....	15
Employees turning 65.....	15
Extension of benefits	15
Over-age dependents.....	15

Balancing employee choice and employer control

An overview of comprehensive coverage.....	16
Health coverage.....	16
Dental coverage.....	17
Vision coverage.....	17
Life coverage	18
Workers' compensation	18

continued on next page

Group requirements and maintenance

Accurate information.....19
 ID cards and certificates.....19
 Employee participation requirements.....19
 Employer contribution requirements.....20
 Anniversary dates.....21
 Employer waiting periods.....21
 Converting part-time employees to full-time employees (and vice versa).....22
 Canceling group coverage.....22
 Nonrenewal of coverage.....22
 Changes in ownership.....22
 Address changes.....22
 Leaves of absence (personal and health).....23
 Benefit modifications.....23
 How to request changes.....24
 Benefit modification job aid (chart showing frequent changes and required documentation).....25
 Continuation of coverage (Cal-COBRA, COBRA, Medicare Part D, HIPAA, conversion).....26
 Grandfathering/Non-Grandfathering.....26

About claims

Filing a claim.....28
 Coordination with Medicare.....28

Value-added services for members

360° Health®.....28
 HealthyCheckSM.....29
 BlueCard®.....29

Forms and supplies

Downloading, requesting and ordering forms.....29

Life insurance

Premiums.....30
 Enrolling new employees.....30
 Changing coverage.....30
 Ending coverage.....30
 Salary-based plans.....30
 Beneficiary designations.....30
 Actions and forms (chart showing frequent actions and required forms).....31
 Waiver of premiums.....31

Workers' compensation

How to submit payment.....32
 How to cancel coverage.....32
 Integrated MediComp savings.....32
 Claims kit.....32
 Health treatment and network kit.....32
 Mandated forms (Posting Notice, Facts About Workers' Compensation, Facts for Injured Workers).....33
 Employee claims for workers' compensation benefits (DWC-1).....33

POP, FSA and COBRA administration

Section 125 Premium Only Plan (POP).....34
 FSA and COBRA administration.....34

We're here to help from 8:30 a.m. to 7p.m., Monday – Friday

Questions about...	Contact	Phone/Fax	Address
Premiums or billing	Enrollment & Billing	Phone 800-627-8797 Fax 805-499-7762	Anthem Blue Cross P.O. Box 54630 Los Angeles, CA 90054-0630
Enrollment or applications	Enrollment & Billing	Phone 800-627-8797 Fax 805-499-0842	Anthem Blue Cross P.O. Box 9062 Oxnard, CA 93031-9062
Cal-COBRA, COBRA, HIPAA and/or Medicare	Enrollment & Billing	Phone 800-627-8797 Fax 805-499-7762	
Health claims	Claims	Phone 800-627-8797	Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007
Dental claims	Dental Services	Phone 888-209-7852	Dental Services P.O. Box 9066 Oxnard, CA 93031-9066
Vision claims out-of-network only	Blue View Vision SM Customer Service	Phone 866-723-0515	Blue View Vision Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111
Life claims	Life Claims	Phone 800-552-2137	Life Claims Service Center P.O. Box 724767 Atlanta, GA 31139-1767
Pharmacy (retail)	Express Scripts	Phone 866-297-1013	Express Scripts c/o Prescription Drug Program (Retail Pharmacy) P.O. Box 145433 Cincinnati, OH 45250-5433
Pharmacy (mail order)	Express Scripts	Phone 888-452-4357 Hearing-Impaired Phone 800-899-2114	Express Scripts (Mail Order) P.O. Box 66558 St. Louis, MO 63166-6658 Expressscripts.com
Coverage while traveling (out-of-state providers)	BlueCard [®]	Phone 800-810-2583	n/a
Forms and supplies	Arvato (Anthem Blue Cross fulfillment vendor)	Phone 877-637-4029 Fax 800-504-1956	anthem.com/ca
Section 125 Premium Only Plan (POP)	Ceridian	Phone 800-767-4969	n/a
Workers' compensation premiums	Employers [®]	Phone 800-677-3252	Employers P.O. Box 52772 Phoenix, AZ 85072-2772
Workers' compensation underwriting	Employers [®]	Phone 800-677-3252	Employers P.O. Box 539004 Henderson, NV 89053
Workers' compensation claims	Employers [®]	Phone 800-677-3252	Employers P.O. Box 539004 Henderson, NV 89053

Go to anthem.com/ca for access 24 hours a day, 7 days a week.

Steve Shorr Insurance - Steve@SteveShorr.com

We hope these self-service options will also be helpful

Internet

For comprehensive resources, please visit our website at anthem.com/ca, click 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.

General resources

Basic tools and information are easy to download and print:

- Employee Applications and Small Group Information Change Forms
- Frequently Asked Questions
- This *Group Administrator Manual*
- Important telephone numbers and addresses
- Additional tools and information as new updates occur

Account access through EmployerAccess

With EmployerAccess, you also enjoy password-protected access to real-time information that makes it easy to manage your Anthem Blue Cross account. Online registration is quick, easy and secure. Then you can log on to:

- Enroll new employees online
- Request ID cards
- View billings
- Change member addresses
- Cancel members
- Pay your bill online

Renewal materials and other documents

Our Small Group Easy Renew sites host all of the applications, forms, rates, brochures and other materials you need for your renewal. However, Easy Renew can be used all year around 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 clicking on the "Forms" tab.

Please give us a call at 800-627-8797 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), which the member selects to view:

- Contract information
- Address information
- Health plan coverage
- Claim status
- Doctors, specialists and hospitals, and their locations, in our network

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 **800-627-8797**. You'll be prompted to say or enter your information. Then simply select menu option 4 to access your group administrator options.

Welcome to the Anthem Blue Cross Small Group Services Department

If you are a plan member	Press 1	If you are a health care provider	Press 2	If you are an Anthem Blue Cross agent	Press 3	If you are a group administrator	Press 4
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When you select option 4 for group administrators, you'll be transferred to a dedicated Customer Service representative. You can also select from a variety of self-service options that allow you to:

- Verify your paid-to date
- Verify an employee's eligibility
- Request ID cards
- Dial an extension
- Verify our phone numbers and addresses
- Request that common forms be faxed to you

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, your group will not receive the increase until the date your guarantee period expires.

Please see the information below, which explains the various components of your premium that are subject to change.

Rates may change at the group level, which affects all enrolled employees. Rates also may change at the individual group member level, which only affects a specific employee. Rates at the employee level may change when dependents are added or deleted, when ages are reached that affect rates or when benefits change. Rates for the group and the employees in the group may also be affected when an address or age category changes.

At the group level, your rate has two components: the **Standard Employee Risk Rate (SERR)** and the **Risk Adjustment Factor (RAF)**.

- The **SERR** is the base premium for each Anthem Blue Cross health product. If your group's SERR changes, we'll notify you 30 days in advance.
- The **RAF** reflects our assessment of your group's particular risk characteristics. Applying the RAF assigned to your group means your actual rate may be up to 10% more or up to 10% less than the SERR for your coverage. We may re-evaluate your group, but we won't change your RAF more often than once in a 12-month period. If your group's RAF changes, we'll notify you 30 days in advance.

Billing cycle

You 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 and any applicable fees. Detach the coupon from the invoice, and include it with your premium payment in the envelope provided. If you don't include the payment coupon, processing for your payment could be delayed. Remember, **you can always make your premium payment online through EmployerAccess**. (If you're not already registered for EmployerAccess, call us at 800-627-8797 for details.) If your group plan includes more than one product from Anthem Blue Cross, you'll receive one consolidated bill for all products.

Please check to make sure each monthly invoice is accurate and notify us immediately at 800-627-8797 if there are discrepancies. It is important that you pay the full amount of the premium listed on the invoice. **Credit won't be processed for retroactive deletions before the month that your group is being billed for**. Separate checks for each of your group's Anthem Blue Cross products are not required.

Important note: **We must receive your payment on or before the due date shown on the invoice, or it will be considered late. Your group policy may be cancelled if we do not receive your 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.

Premium payments

Nonpayment of premiums due

We reserve the right to **end your Small Group coverage** for nonpayment. If you don't remit your payment on time, your Small Group policy will be terminated, effective on the first day after the grace period ends. **The grace period is the last business day of the month. 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 don't pay the final month's premium, your account may be subject to collection.

Note: See your group contract for more details.

Premium payments (continued)

Adjustments to your bill – employee/dependent additions and deletions

It's important to pay the premium amount listed on your bill. Please don't include premiums for new employees who are being added to the group or who don't appear on the bill. These premiums will be included on a later bill, after we have processed and approved the applications. Please don't submit new applications or any correspondence with your bill, because this may delay payment processing. Send applications for new employees when they become eligible to enroll. (See the chart on page 1 for the fax number for submitting applications.) Our Membership Services team will process applications upon receipt per your group's waiting period.

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 employee may not be able to recover. Credit for terminations will be reflected on your next scheduled billing statement after we have processed the deletion(s).

Important note: Please do not submit termination(s) with your premium payment. If you do, the terminations may not be processed because they will go to the premium payment lock-box, not directly to Anthem Blue Cross. Instead, please send terminations to the address or fax number shown on the Small Group Information Change Form (#5063). Failing to pay your premium, or submitting membership changes by marking your invoice, does not meet the notification requirements for terminating an employee or dependent from your policy.

Preparing your payment

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

Where to mail your payment

You can help us process your premium payment promptly by following the steps listed above under "Preparing your payment." Mail your check and the coupon only to **Anthem Blue Cross, P.O. Box 54630, Los Angeles, CA 90054-0630.**

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 your convenience, you can call **800-627-8797** and pay by phone from your checking account. We will charge a fee for this service, and an electronic Bank Authorization Form must be on file.

Pay online

You can also make your payment online through EmployerAccess. There is no administrative fee for online premium payments. If you're not already registered for EmployerAccess, call us at **800-627-8797** for details.

Administrative fees

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

- **Phone payment fee (for pay by check only)**

We charge a fee for this service.

- **Reinstatement fee**

If your policy is canceled for not complying with the contract, and the policy is later reinstated, there will be a \$50.00 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 Blue Cross' sole discretion.

- *Note: Groups requesting reinstatements due to non-payment will need to contact Accounts Receivable Collections (ARC) at 888-686-9807.

- **Returned check fee**

We will charge a \$25.00 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 second returned check in a 12-month period, you must submit all future premiums in certified funds. Certified fund remittances will be examined at our lock box before posting to ensure it complies with requirements. The certified funds requirement may be removed after you re-establish a timely payment pattern. A third returned check in a 12-month period your policy will be automatically cancelled.

Important note: 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.

- **Late payment fee**

We may assess a \$25.00 late charge on the 15th day of the month for which the premium is due. Example: The bill for an April 1 payment is generated on March 1. The bill will be considered late if it is not paid by April 15, and a late charge will be assessed and reflected on the group's next billing statement.

- **Credit card payments are not accepted at this time.

Enrollment guidelines

Eligible employees

To be eligible for coverage, an employee must be in an enrollment class that is included in the group's **Master Application** submitted to and accepted by Anthem Blue Cross.

- **Full-time employees**

A full-time employee must be actively doing business, with a normal work schedule of **30 or more hours per week**.

Only those employees whose wages are reported for tax purposes under the group's federal tax identification number on a W-2 form are eligible for enrollment.

- **Part-time employees**

A part-time employee must be actively employed on a permanent, part-time basis and must be compensated for that work by the employer (subject to withholding appearing on a W-2 form). Part-time employees are not automatically included in the group's contract unless specifically requested when the group is formed or added at a later date (see "Benefit modifications" in the **Group requirements and maintenance** section). Only those employees whose wages are reported for tax purposes under the group's federal tax identification number on a W-2 form are eligible for enrollment. Employers may extend coverage to employees who work **either** at least 20 but no more than 29 hours, **or** at least 15 but no more than 29 hours, per normal workweek for at least 50% of the previous calendar quarter. If you choose to cover part-time employees, the option must be offered to all part-time employees.

- **Sole proprietors/partners/corporate officers**

Sole proprietors, partners and corporate officers must be actively doing business on a full-time basis, with a normal schedule of at least 20 hours per week.

Employees who live outside California

Employees who live outside California may also be eligible for certain coverage. **At least 51% of all employees must be employed in California.**

Important note: Plans available to employees living in other states may be different than those of California residents. **Anthem Blue Cross HMO plans are only available to employees who live in the areas of California served by the Anthem Blue Cross HMO networks.** Contact your agent or our Membership department for more information.

Ineligible employees

Temporary, substitute, contract, leased or seasonal employees (defined as "employees hired with a planned future termination date") or persons compensated on an IRS 1099 Form substitute basis are **not** eligible for coverage.

Enrolling new employees

To enroll a new employee you must complete an Employee Application. We must receive the completed application after the employee's date of hire and before the last day of the month following the end of your group's waiting period. We also must receive an application no later than the last day of the month in which the employee is eligible. Please note that there are **no exceptions** to these requirements. Incomplete applications will not be processed, which may delay your employee's coverage effective date. If we get an application more than 31 days after the employee's eligibility date, the employee will be considered a late enrollee and coverage may be delayed for up to 12 months (see "Late enrollees/open enrollment" in the **Enrollment guidelines** section).

You must make sure that sections 2 and 4 of the Employee Application (sections 3 and 5 of the BeneFits Employee Application) are completed for any employees and/or eligible dependents who decline coverage.

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

You can also enroll a new employee (and dependents if applicable) online. Please see "Internet" in the **How to get help** section for more information.

Important note: Please make sure that an application for each eligible employee who is applying for or declining coverage is sent to us in a timely manner. Failure to do so may delay coverage, which may expose you to liability to the employee and Anthem Blue Cross. Remember that you can enroll eligible employees online through EmployerAccess. If you aren't registered yet for EmployerAccess, please call us at 800-627-8797 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.

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
- The waiting period selected by the employer (see page 21 for more details)
- Late enrollee classification, as defined under HIPAA
- The date we receive the fully completed application

Effective dates are determined as follows:

- If we receive the fully completed application before the employee's waiting period is over, the effective date will be the first day of the month following application approval and waiting period.
- If we receive the fully completed application after the employee's eligibility date, but within 31 days of the date when the employee becomes eligible, the effective date will be the first of the month that coincides with end of the waiting period.
- If we receive the application more than 31 days after the employee's eligibility date, the applicant may be considered a late enrollee as defined under HIPAA, and the effective date may be delayed for up to one year from the enrollment application date.

Applications with missing information are considered incomplete and may be returned. **In those cases, we will use the date that we receive the fully completed application to determine the coverage effective date.** We must receive fully completed applications before the requested coverage effective date and within the eligibility period.

Coverage effective dates (continued)

Examples of effective dates for eligible employees:

	Example 1 Employee submits application within time frame	Example 2 Employee submits application late
Hire date	4/3/11	4/3/11
3-month waiting period	7/3/11	7/3/11
Eligibility date	8/1/11	8/1/11
Completed application received	8/15/11	9/2/11
Effective date	8/1/11	10/1/11

Examples of effective dates for eligible employees who decline coverage:

	Example 1 No qualifying event	Example 2 Employee who has experienced a qualifying event
Hire date	4/3/11	4/3/11
3-month waiting period	7/3/11	7/3/11
Eligibility date	8/1/11	8/1/11
Declination of coverage received	8/15/11	8/15/11
Employer anniversary	3/1/12	3/1/11
Date of qualifying event	N/A	10/15/11
Completed application received	3/5/12	11/5/11
Effective date	3/1/12	11/1/11

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 you. If the employee is rehired **more than** 31 days after the termination date, the employee is considered a new employee, subject to applicable waiting periods, and must complete a new Employee Application. The group is responsible for notifying us immediately if an employee is rehired and will be continuing coverage.

Eligible dependents

Dependent coverage is not automatically included in the eligibility definitions of the Anthem Blue Cross contract and is considered an expansion of eligibility. Dependent coverage is included at the request and discretion of the employer. If you have extended eligibility to include dependents, it must be offered to all dependents of eligible, enrolled employees. The following persons, if not otherwise covered as subscribers by your Anthem Blue Cross plan or in military service, are considered eligible dependents:

- Lawful spouse or registered domestic partner
- Any biological or legally adopted child (see “Enrolling eligible dependents” in the **Enrollment guidelines** section) of the subscriber or the subscriber’s enrolled spouse/registered domestic partner
- A stepchild of the subscriber or the subscriber’s enrolled spouse/registered domestic partner
- A child (ward) of the subscriber or the subscriber’s enrolled spouse/registered domestic partner who is named the ward’s permanent legal guardian

Domestic partners

Anthem Blue Cross automatically provides Small Groups with benefits for registered domestic partners.

Please note: If the documentation required for a registered domestic partner is not provided with a completed Employee Application, we will request the documentation and hold the application as pending, which may delay the coverage effective date. If we don't receive the required documentation, we will return the application.

When an eligible employee requests self-coverage but declines coverage for a domestic partner, the employee must complete the declination section on the Employee Application.

If a domestic partnership terminates, the employee must notify the group administrator and provide a signed, notarized copy of the Affidavit of Termination of Domestic Partnership within 31 days of the termination. That employee may not enroll a new domestic partner in the group’s plan until six months after the previous domestic partner was removed from the plan.

Eligible dependents (continued)

What is a "domestic partner"?

Domestic partner is defined in Family Code Section 297 (which was established by AB 205 in 2003) as follows:

(a) Domestic partners are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring.

(b) 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:

- (1) Both persons have a common residence.
- (2) 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.
- (3) The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
- (4) Both persons are at least 18 years of age.
- (5) Either of the following:
 - (A) Both persons are members of the same sex.
 - (B) 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.
- (6) Both persons are capable of consenting to the domestic partnership.

(c) "Have a common residence" means that both domestic partners share the same residence. It is not necessary that the legal right to possess the common residence be in both of their names. Two people have a common residence even if one or both have additional residences. Domestic partners do not cease to have a common residence if one leaves the common residence but intends to return.

Is a domestic partnership a same-sex relationship or an opposite-sex relationship according to Family Code Section 297?

Family Code Section 297 states that same-sex domestic partners (age 18 and older) can legally register as domestic partners. Persons of the opposite sex do not constitute a domestic partnership unless one or both persons are age 62 or older and eligible for Social Security.

Anthem Blue Cross **will** cover opposite-sex domestic partners under age 62 unless the employer opts not to offer such coverage. If your group chooses **not** to cover opposite sex domestic partners **under** age 62, you must submit a statement to Anthem Blue Cross, on company letterhead and signed by an owner/officer of the company, indicating that decision.

Does the requirement to provide health coverage to an employee's domestic partner extend to the children of the domestic partner?

Yes, the children of the domestic partner will be covered on the same basis as other eligible dependents. The law requires that coverage be provided to a registered domestic partner to the same extent and subject to the same terms and conditions as provided to a spouse. If the plan covers children of the employee's spouse, it must also cover the children of an employee's legally registered domestic partner.

Can groups, such as religious groups, opt out of domestic partner coverage?

No. The law requires that health plans and health insurers include domestic partner coverage in their group contracts and policies, and makes no exceptions for contracts or policies issued to a religious employer or any other type of employer.

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 overage dependent of the subscriber or the subscriber's enrolled spouse/registered domestic partner, from the child's 26th birthday and older, who is:
 - Incapable of self-sustaining employment due to a physically or mentally disabling injury, illness or condition, and a physician has certified the child's physically or mentally disabling injury, illness or condition in writing; and

Please see the "Over-age dependents" subsection on pages 15-16 for information about the documentation and time frames required for continuing coverage for dependents who have reached the limiting age.

The application for coverage for a dependent child must be submitted to within 31 days of the child's eligibility. Coverage will begin on the first day of the month following our receipt of the completed and approved Employee Application.

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

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 first day of the month following our receipt of documentation: <ul style="list-style-type: none"> · New spouse: no documentation required · Same-sex new domestic partner: no documentation required · Opposite-sex new domestic partner: No documentation needed 	Within 31 days of new marriage or new domestic partner registration	Employee Application
Newborn Child Coverage of newborns is automatic only for the first 31 days following birth. Employees must request to enroll newborns. This can be done by phone within the first 31 days following birth. After 31 days, an Employee Application must be completed. Otherwise, coverage terminates at the end of the 31-day period. Payment of claims for birth-related expenses is not an indication of continued coverage. The employee must request the addition of a new dependent.	Within 31 days of birth	Verbal or written notice by calling our Membership department at 800-627-8797
	After 31 days of birth	Employee Application
Adopted Child A child who is in the process of being adopted is considered a legally adopted child if Anthem Blue Cross receives legal evidence of intent to adopt or notification of physical custody, and the subscriber or spouse/domestic partner has the authority to control the health care needs of the child or has assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption.	Within 31 days of adoption or the right to control health care	Employee Application 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 31 days of marriage or new domestic partner registration	Employee Application Legal documentation of marriage or domestic partner registration
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 31 days of issuance of the final court decree or order of legal guardianship	Employee Application Letter of Guardianship form from the court, showing the filing date and court seal
Late Enrollee Dependents Dependents are considered late enrollees if coverage is not requested within the required time frame: <ul style="list-style-type: none"> · If Anthem Blue Cross receives a fully completed application after the eligibility date, but within 31 days of the dependent becoming eligible, coverage can be effective the first of the month following approval of the application. · If we receive the completed application more than 31 days after the eligibility date, the dependent may be considered a late enrollee under HIPAA and the effective date may be delayed up to one year from the application date. 	During the group's open enrollment period (Anthem Blue Cross anniversary) Before conditions that would otherwise cause a dependent to be a late enrollee	Employee Application Proof of qualifying event

Enrolling eligible dependents (continued)

Applications with missing information are considered incomplete and may be returned for completion. 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.

Declinations

New employees who don't elect coverage or existing employees who choose to end coverage under your Anthem Blue Cross Small Group policy must complete sections 2 and 4 of the Employee Application. 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 declining 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 decline coverage, he or she may be eligible to reapply at a later date. If an employee applies after the eligibility period has expired and we did not previously receive a declination, the employee may be considered a late enrollee and be subject to late enrollee guidelines.

Late enrollees/open enrollment

If we receive a new Employee Application more than 31 days after the applicant becomes eligible, the subscriber and eligible dependents will be considered late enrollees and may have to wait until the group's anniversary date for coverage. This is known as "open enrollment."

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 declined coverage and now want to enroll must complete an Employee 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 Combined Evidence of Coverage and Disclosure Form and/or Certificate for exceptions that apply to special enrollment periods.

Pre-existing conditions

A pre-existing condition is an illness, disease or physical condition for which alling advice, diagnosis, care or treatment, including the use of prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately before the earliest of either the first day of the waiting period or the date the member's coverage begins.

Under the terms of your Anthem Blue Cross Small Group policy, new employees and their dependents, if any, may be subject to pre-existing condition limitations and exclusionary periods. Pre-existing condition limitations and some exclusionary periods do not apply to employees and their dependents if an HMO plan is selected. Pre-existing condition limitations and exclusionary periods do apply with any PPO plan selected, except for employees and their dependents under age 19. There is also an exception for certain dental plans.

Please refer to your Combined Evidence of Coverage and Disclosure Form and/or Certificate for a detailed explanation of pre-existing conditions, limitations and exclusionary periods.

Where to submit applications

Submit all completed Employee Applications to one of the following:

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

Fax: **805-499-0842**

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

Employee application tips

- Use black or blue ink and print clearly and legibly.
- Include your Small Group number at the top of the application.
- Make sure all required areas of the form are completed.
- If an HMO plan is selected, a primary medical group (PMG) or independent practice association (IPA) and office number are required.
- If Dental Net is selected, a dental office and office number must be selected.
- All information in section 3 must be completed.
- Social Security or ID number(s) are required.
- The employee must either enroll or decline coverage for all eligible dependents.
- Information on previous coverage is critical; be sure to submit proof of prior coverage (if applicable) and provide a copy of a Medicare ID card (if applicable).
- The last page of the application must be signed and dated by the employee.
- Employees who request life insurance must name a beneficiary.
- Incomplete applications may be returned, which will delay the coverage effective date.

Enrollment actions guide	How this action can be done:				Comments
	Internet EmployerAccess	Employer Application	Employee Application	Small Group Information Change	
Action					
Add a new employee and/or dependents to the plan	x		x		Additional documentation may be needed, depending on the type of dependent.
Add dependents for an existing employee	x		x		
Decline coverage for an employee and/or dependents			x		Sections 2 and 4 of the Employee Application must be completed.
Change plans for employees or dependents who already have coverage			x		Changes can only be requested on the group's anniversary date.
Terminate an employee and/or dependents from the plan	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	An Employee Application must be completed to avoid delays if coverage is selected at a later date.
Change an employee's address (Please note: This may affect the employee's rate.)	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	Complete the Small Group Information Change Form.
Remove a subscriber from federal COBRA	x			x	Complete the Small Group Information Change Form.
Change the employer's address	x	x		x	You can also submit a written request on the employer's 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 gives you convenient, password-protected access for administering your group's account. See the **How to get help** section for details.

Membership changes

Deleting employees from the plan

Use the **Small Group Information Change Form** to delete employees from the plan. Employees may be deleted due to termination of employment, ineligibility for coverage under the plan, or when the employee wants to end coverage regardless of his or her employment status and/or eligibility. An employee's coverage under the plan must be canceled if:

- Employment is terminated.
- An eligible full-time employee changes to part time, and the group's plan does not cover part-time employees.
- An employee is on a leave of absence (health and/or personal) and the time period that the employer covers employees on leave has expired.
- An eligible part-time employee's work is permanently reduced to less than the minimum number of hours per week, based on whether the employer has elected to offer coverage for those who work:
 - 15-29 hours per week, or
 - 20-29 hours per week
- An eligible employee becomes ineligible by becoming a temporary, substitute, seasonal, leased or contract employee, or becoming an employee whose compensation is reported on an IRS 1099 Form.
- An employee otherwise becomes ineligible to participate in the plan.
- The employee no longer wants to continue federal COBRA coverage.

Deleting terminated employees

To delete a terminated employee, fully complete section 1 of the **Small Group Information Change Form**. Please include the following information: employee and/or dependent names, identification number, termination date, request for COBRA or Cal-COBRA, and the qualifying event for termination. You must notify Anthem Blue Cross about employment notifications on a timely basis and in writing by completing the Small Group Information Change Form. If the employee requests Cal-COBRA, make sure all required information is included. Due to the notification requirements mandated by Cal-COBRA and COBRA, we recommend that you report terminations to Anthem Blue Cross as they occur. Please fax termination notices to us at **805-499-0842** or mail them to:

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

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

If you fax the termination documentation, you don't have to mail the originals to us. Employers are required by law to allow 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.

Important note: Due to state and other regulations, **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 Blue Cross is notified about the COBRA election, the member will be enrolled under the group's COBRA benefits. **The employer is obligated under law and by contract with Anthem Blue Cross to notify employees of their termination of coverage and of any rights to continue coverage. Failure to do so exposes the employer to liability to the employee and to Anthem Blue Cross. 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 Blue Cross does not accept retroactive terminations.

Deleting employees who remain eligible but discontinue coverage

Please indicate the following information on the Small Group Information Change Form or in a request submitted on company letterhead: identification number, employee and/or dependent names, which coverage is being deleted, the reason for coverage cancellation and the effective date.

Please remember that sections 2 and 4 of the Employee Application must be completed for those employees who are still employed but canceling coverage. This is in accordance with California law (AB 1672).

You must complete section 2 of the Small Group Information Change Form or provide written instructions on company letterhead and submit it to us with the Employee Application Coverage will end on the last day of the month in which we receive notification of the termination.

Employees enrolled in the plan who remain employed and who choose to end coverage may be considered late enrollees if they want to re-enroll for coverage later. If that then, the coverage effective date may be delayed until the group's anniversary date. The employee would have to reapply then.

Deleting COBRA members

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

COBRA-eligible dependents

If a dependent becomes eligible for COBRA, please complete section 1 of the Small Group Information Change Form and submit it to us. A dependent is eligible when the subscriber divorces, the subscriber dies, a dependent child becomes over-age 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 the group's Medicare and COBRA status.

Employees turning 65

Medicare is the primary payer for employees age 65 or older in employer groups with fewer than 20 employees (based on 20 or more calendar weeks in the previous calendar year). Anthem Blue Cross is not a supplement to Medicare. For information about their coverage options, employees who are approaching age 65 should consult their Combined Evidence of Coverage and Disclosure Form/Certificate or contact Customer Service before they become eligible for Medicare. **Those members should also contact the Social Security Administration before they turn 65.** Please note that premium rates are affected when the member turns 65.

Extension of benefits

The plan provides for a limited extension of benefits if coverage terminates, the member is totally disabled and certain other criteria are met. The extension (up to 12 months) covers only the totally disabling condition and is subject to review every three months. An extension of benefits must be requested in writing or by calling 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 to the child's 26th birthday or beyond if certain conditions are met and the parent provides the required documentation to Anthem Blue Cross. When a dependent child's coverage will terminate because the child will reach the limiting age, we will notify the subscriber at least 90 days before the child reaches that age. The subscriber then must submit a request for continued coverage for the child, along with proof of the applicable criteria described on Pages 10-11, 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 don't 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.

Over-age dependents (continued)

If the requested coverage is due to a court order: We must receive a copy of the court order, or receive a request from the district attorney, either parent or the person who has custody of the child, the employer, or the group administrator. We will request information that the child meets the coverage criteria, and the subscriber must submit the information within 60 days of receiving our request. We will determine if the child meets the criteria for coverage. An application for coverage must be submitted to us within 30 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 Blue Cross coverage: We will request information that the child meets the applicable coverage criteria described on pages 10-11. The subscriber must submit that information within 60 days of receiving our request. 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.

Balancing employee choice and employer control

An overview of comprehensive coverage

You can build a health care coverage package that meets your needs and gives your employees peace of mind. And you can wrap it up with one consolidated invoice.

- **Health** – start with a strong foundation
- **Dental** – add even more value
- **Vision** – build a clearly superior benefits package
- **Life** – provide security and peace of mind
- **Workers' compensation** – fulfill state requirements and save money at the same time

Health coverage

We recognize that companies have different needs when it comes to health coverage for their employees. That's why we offer a wide range of health plan solutions.

EmployeeElect

Standard employee participation and employer contribution requirements apply (see page 20), with a broad range of plans to choose from and the flexibility for future changes.

- A distinctive mix of PPO, HMO and consumer-driven health plans so you can find the ideal balance between cost and benefits. (Please note our Power SelectHMO plan cannot be offered along with any of our other HMO plans.)
- Integrated billing and customer service that make it easy to offer as many plans and types of coverage as you want
- Three options for setting your contribution for employees' health premiums, so you get financial control

BeneFits

BeneFits is a unique solution designed especially for cost-conscious employers or those who are offering health care benefits for the first time. We start with basic coverage and add benefits from plan to plan. Coverage is easier to understand, easier to afford and easier to qualify for.

- Six progressive plans that include two comprehensive coverage options, a consumer-driven health plan, and one plan with built-in dental and vision benefits
- All-in-one package – so you decide how many plans to offer your employees
- More affordable rates
- Lower employee participation and employer contribution requirements (see page 20)
- All the advantages that Anthem Blue Cross coverage helps employers enjoy – guaranteed issue, potential tax savings for your company, a 12-month rate guarantee, as well as discounts and savings when you purchase our specialty products (dental, vision, life, workers' compensation) with health coverage

You can find more information about our BeneFits portfolio online at anthem.com/ca.

EmployeeChoice

If you want the option to offer your employees an HMO plan from another carrier, consider our EmployeeChoice portfolio.

- Five of our popular plans
- At least five employees must enroll
- Standard employer contribution requirements also apply to EmployeeChoice. Plus, just like with EmployeeElect, you can integrate workers' compensation, add dental, vision and life, and receive special discounts and savings.

Dental coverage

Spending just a little on a complete health care package may save you a lot, especially when dental coverage is part of the picture. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company offers a variety of dental PPO, dental DHMO and voluntary dental plans — all specifically designed for small businesses like yours. You can pick what works best for you and your employees and be confident that you made the right choice. And, just like with our health plans, the amount you contribute toward premiums is up to you...your employees pay the rest through payroll deductions.

Dental Blue® plan highlights

- Diagnostic and preventive services like exams, cleanings and X-rays – at no cost when using an in-network provider
- Fillings covered at 80% (or even 90%) when using an in-network provider
- Coverage for more extensive services like oral surgery, crowns and root canals
- Orthodontic services covered on most plans
- Out-of-network reimbursement at the 80th percentile
- No waiting periods, so employees can take advantage of their dental plan right away
- Dental Blue members who are pregnant or living with diabetes can receive one additional dental cleaning or periodontal maintenance procedure a year. And we'll also reach out to them with our Future Moms and ConditionCare: Diabetes programs if they are enrolled in the 360° Health® program.

Dental PPO plan highlights

- The freedom to choose any dentist or specialist participating in our Prudent Buyer network (no referrals needed)
- Access to quality care at discounted fees
- Coverage for both routine visits and more extensive procedures

Dental HMO plan highlights

- Choice of dentists participating in our Dental Net HMO network (out-of-network services are not covered)
- Dentist coordinates care, including specialist referrals
- Lower out-of-pocket costs with no annual deductibles or maximums
- No waiting periods
- Orthodontic services for children and adults

Voluntary Dental PPO and Voluntary Dental HMO plan highlights

- Diagnostic and preventive care available immediately after approval
- The employer isn't required to contribute to employees' monthly premiums
- Employees can pay up to 100% of the premium cost
- Two or more eligible employees must be enrolled in Anthem Blue Cross health coverage
- Only three employees or 25% of eligible employees (whichever is greater) must enroll in voluntary dental coverage
- Premiums must be paid through payroll deductions
- There are two plan choices – a dental PPO and a dental HMO

Vision coverage

Comprehensive, inexpensive vision plans can play a role in managing the overall health and well-being of your employees. It's been shown that regular eye exams and wearing corrective eyewear can greatly decrease the risk of more serious, long-term eye diseases and can even result in early detection of other health conditions* — increasing your employees' productivity and performance. You get the picture, and so do we. That's why we've created Blue View Vision. Our Blue View Vision plans include:

- Access to a broad, convenient, national network of more than 50,000 providers and provider locations, including many independent optometrists and ophthalmologists, as well as national retail locations such as LensCrafters®, Pearle Vision®, Sears OpticalSM, Target Optical® and JCPenney® Optical

- These retail locations offer convenient evening and weekend hours, allowing your employees to schedule appointments outside their normal work day.
- Value-added savings where employees enjoy additional savings of 15% to 40% on unlimited purchases of most extra pairs of eyewear, conventional contact lenses, lens treatments, specialized lenses and various accessories — even after they've exhausted their covered benefits.
- Factory scratch coating on eyeglass lenses included at no additional cost
- Transitions® and polycarbonate lenses for children under 19 years old at no additional cost
- Transitions lenses for adults at a fixed price of \$75
- Tiered pricing for premium progressive lenses and premium anti-reflective coatings, limiting members' out-of-pocket costs
- Members who have our vision coverage and our 360° Health® program included in their health plan may now be enrolled in our ConditionCare: Diabetes program if their vision claims include a diabetic-related diagnosis.

*American Optometric Association, aoanet.org.

Life coverage

Your employees depend on you, and their families depend on them. Life insurance is an easy, inexpensive way to help your employees improve their families' financial security. Your employees will appreciate that you took the time to include their families' future in your company's benefits package. What's more, Anthem Blue Cross Life and Health Insurance Company is rated "A (Excellent)" for financial strength by A.M. Best Company and "A+ (Superior)" for claims-paying ability by Standard & Poor's — which says a lot, especially during these rough economic times.

- Basic term life coverage from \$15,000 to \$250,000 is available and includes Accidental Death and Dismemberment (AD&D) benefits.
- Groups that offer \$25,000 or more in basic term life coverage may be eligible to receive a 1% savings on their health premium, and they also receive a valuable member assistance program at no additional cost to help enrolled employees get referrals for counseling, treatment and therapy.
- Two dependent life coverage options are available (employer contribution isn't required).
- Supplemental life coverage is also available and it allows employees who are enrolled in their group's basic term life coverage to purchase additional life coverage for themselves. Employer contribution isn't required.

Save with composite rates

All new groups of 11 or more enrolling employees automatically get the advantage of composite life rates. This means that employers receive a single rate per \$1,000 in life coverage, regardless of the age or gender of those enrolling.

Workers' compensation

Anthem Blue Cross and Employers® have joined forces to integrate health coverage and workers' compensation in one convenient, cost-effective program.

Integrate and save

When you integrate workers' compensation from Employers with your Anthem Blue Cross health coverage, you receive:

- **An automatic 10% discount** on the workers' compensation portion of your integrated bill
- **Potential additional savings** on the health portion of your integrated bill if you qualify (underwriting is required)

More advantages of integrating with health

In addition to substantial savings, you and your employees receive many other advantages when you integrate workers' compensation with health coverage:

- There's one managed care provider network for both personal health and workers' compensation.
- An employee's network family doctor can treat both personal illness and work-related injuries and refer the employee to specialists when necessary.
- You enjoy easy administration through one consolidated bill and point of contact.

Nearly half of workers' compensation claims are for health expenses. By reducing health expenses using the lower Anthem Blue Cross-negotiated network fees, you also have the potential for long-term savings on workers' compensation premiums.

Group requirements and maintenance

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 age 65. You must also notify us about changes that affect your group. These changes include, but are not limited to, a address change, 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 the group's COBRA, Cal-COBRA or Medicare payee status. You must submit information about these and other events within the time frames that are outlined in your Combined Evidence of Coverage and Disclosure Form/Certificate.

Important note: Failure to provide updated eligibility information may delay coverage or cause premium inaccuracies that your group or your employee may not be able to recover.

ID cards and certificates

All enrolled employees will receive a Combined Evidence of Coverage and Disclosure Form/Certificate and Anthem Blue Cross identification cards. If these items are sent directly to you, then you are responsible for distributing them.

Employees' ID cards show their name and the coverage selected. ID cards aren't automatically generated for each dependent. **PPO plan members will receive ID cards that list only the employee's name, even if other family members are covered.** This card is valid for all of the employee's covered family members. If an employee selects an HMO plan and the employee's spouse or dependents choose a different participating medical group (PMG) or independent practice association (IPA) than the employee, we'll issue a separate ID card that shows the spouse's or dependent's PMG or IPA. Additional cards can be ordered through our Membership department. Replacements for ID cards that are lost or destroyed can be ordered online, by calling Customer Service or by using our automated phone system's self-service features.

Employee participation requirements

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

To calculate employee participation, start with the total number of employees, including the company's owner(s). Next, subtract the number of employees with allowable waivers (e.g., employees with Medicare/MediCal/military, those covered as a dependent on a spouse's or parent's employer-sponsored group plan, and for EmployeeChoice only, those who enrolled in the other carrier's HMO plan sponsored by their employer). The result indicates the total number of eligible employees. Then subtract the number of employees who aren't participating for other reasons (e.g., employees who want to remain on an existing Individual plan 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 the group's participation. (See page 20 for an illustration of how to calculate employee participation.)

More on Participation

More about group requirements and maintenance

The examples below show how employee participation may be calculated for a small business (including the owner).

	EmployeeElect	EmployeeChoice*	BeneFits
Total Employees	30	15	8
Waive those who don't participate for allowable reasons			
-Employees covered by MediCal	-1	X	-1
-Employees with military coverage	-1	X	-1
-Employees covered by spouse's employer group plan	-4	-1	X
-Employees covered by parent's employer group plan	-2	-1	X
-Employees covered by other employer-sponsored HMO* plan	X	-1	X
Eligible Employees	22	12	6
Subtract those who don't participate for other reasons			
-Employees who want to keep existing Individual plan coverage	-1	-1	-1
-Employees who simply don't want to participate	-3	-2	-1
Eligible Enrolling Employees	18	9	4
Participation Percentages	82%	75%	66%

*For EmployeeChoice, please note that a minimum of five (5) employees must enroll with Anthem Blue Cross, and Anthem Blue Cross has no influence on the participation of the carrier who provides the employer's other HMO plan.

A group's participation percentages must be:

- 75% for EmployeeElect and EmployeeChoice health plans and all specialty products (dental, vision and life)
- 60% for BeneFits health plans

The number of eligible enrolling employees is divided by the number of eligible employees to yield the group's participation percentage. In the examples above, each group qualifies for coverage. Groups must maintain the minimum participation requirement for their coverage, or they will be subject to nonrenewal.

Special provisions

- If the employer pays 100% of the employees' health, dental and/or life premiums, then 100% of the eligible employees must participate.
- To offer voluntary dental, at least two eligible employees must be enrolled in Anthem Blue Cross health coverage, and at least 25% or three eligible employees (whichever is greater) must enroll in voluntary dental coverage.
- Supplemental life participation requirements vary by group size: For groups of 2-3, 100% participation is required; for groups of 4-10, at least three eligible employees must participate; for groups of 11-50, 25% participation is required.

Employer contribution requirements

Employers can share monthly premium costs with their employees. The employer chooses a contribution option and pays at least a minimum amount of each employee's monthly premium (dependent contributions are optional). Employees cover any remaining premium balance themselves through payroll deductions.

Type of Coverage	Employer Contribution Options		
	Traditional (percentage applied to all plans employees are enrolled in)	Percentage and Plan* (percentage based on the price of one designated plan only)	Fixed Dollar (dollar amount, in \$5 increments, applied to all plans employees are enrolled in)
Health Plan Portfolios/Programs			
EmployeeElect	50% to 100%	50% to 100%	\$100 or more
EmployeeChoice	50% to 100%	50% to 100%	\$100 or more
BeneFits	25% to 100%	25% to 100%	\$50 or more
Dental	50% to 100%	N/A	\$15 or more
Vision	50% to 100%	N/A	N/A
Life	25% minimum employer contribution		

*The Percentage and Plan option is available only for health coverage. The premium price of the Basic PPO plan from Anthem Blue Cross Life and Health Insurance Company cannot be designated as the basis for the employer's contribution.

Anniversary dates

Your group's anniversary date is the month and day your policy became effective and coverage started. **Your anniversary date cannot be changed.** Your anniversary date is important because there are certain actions and changes that can occur only on that date. These activities include the following:

- Change from one type of plan to another type of plan that the employer already offers
- Request that part-time employees be added as a class of eligible employees
- Request a review of the group's Risk Adjustment Factor
- Request to change the employer's contribution approach
- Request to add employees and/or dependents who previously declined coverage

If your group's original effective date is the 15th of the month, your anniversary date is the 1st of the following month (e.g., if your original effective date is January 15 of one year, then your anniversary date is February 1 each year after that).

Employer waiting periods

Your group chooses the 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 or decline to participate in your group benefit plan. You can choose a waiting period of one, two, three, four, five or six months, or no waiting period, which is the first of the month following the employee's hire date. The first available effective date for new employees is the first day of the month following or coinciding with the month the waiting period ends.

You can choose two different waiting periods to accommodate different classes of employees, as long as each employee class that is eligible for each type of waiting period is distinctive and clearly defined. When completed Employee Applications are submitted, they must include clear instructions about which waiting period applies. We may require verification that an employee qualifies for the requested waiting period. If an employee isn't eligible for the waiting period requested, we won't process that employee's Enrollment Application.

New groups may request a change in their waiting period six months from the date their policy became effective. The group can request a waiting period change once every 12 months. The request must be made in writing on the group's company letterhead and must be signed by an owner/officer of the company. If approved, the change will be effective on the first of the month after we receive the request.

Your group's waiting period is applied to all employees in the group, with no exceptions or waivers for any eligible employee. We will not honor any special hiring arrangements that differ from the group's existing waiting period. Waiting periods cannot be changed retroactively. Employees hired before the effective date of the new waiting period will be subject to the previous waiting period.

More about group requirements and maintenance

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

Coverage for part-time employees is considered an extension of eligibility and is offered at the your discretion. If you choose not to offer benefits to part-time employees, then part-time employees cannot enroll. Part-time employees who become full-time employees are eligible to enroll as of the date they become a full-time employee. A full-time employee is defined as any permanent employee who is actively conducting your business with a normal workweek of at least 30 hours (at your regular place of business) and who has met any applicable waiting period requirements. The enrollment procedures for new employees apply, including completing and submitting an Employee Application within 31 days of the employee becoming full-time.

The employee's enrollment is subject to the group's waiting period. The waiting period begins on the date the employee begins full-time employment.

Previous part-time employment is not credited toward the waiting period unless the employee has worked for you 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 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).

Canceling group coverage

If you decide to end your group's coverage, please notify us immediately in writing. The written notice must be on company letterhead and be signed by an owner/officer of the company. You are responsible for notifying employees in a timely manner when coverage has been canceled.

Nonrenewal of coverage

We reserve the right to cancel 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

The employer is responsible for informing employees when coverage has been terminated.

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 the 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 Blue Cross also must be notified if the name of the company or its federal tax ID number changes. Your group benefit agreement is not assignable or transferable, and it may not, among other things, be transferred as part of a sale of the assets of the business.

Address changes

Please submit company and employee address changes to us in writing. Only your authorized representative or the employee can initiate an address change. Please submit **employee** address changes on a Change of Coverage Application or Small Group Information Change Form. Submit an **employer** address change on an Employer Application or on company letterhead with the signature of an owner/officer of the company. You can also submit address changes online through EmployerAccess. (If you haven't registered for EmployerAccess, please call us at 800-627-8797 for details.) Please note that address changes may affect the available plan selections and current rates, so it's important to notify us about these changes in a timely manner. And although we recommend that you submit employee address changes in writing or online, you can also do so over the phone.

Leaves of absence

Short-term personal leave of absence

The employer determines 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 approved by the employer, enrolled employees are eligible to continue group coverage for themselves and their enrolled dependents for the period of time, up to three months, indicated in the group's application. Monthly premiums will continue to accrue during an employee's short-term personal leave of absence, and the employer must continue to pay the required monthly premiums. However, you can request that the employee pay the premiums during this period.

Please note that Anthem Blue Cross has no obligation and the employer has no right 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 begins and end dates.

Short-term medical leave of absence

Your group determines 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 approved by the employer, enrolled employees are eligible to continue group coverage for themselves and their enrolled dependents for the period of time, up to six months, indicated in your 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 during this period.

Please note that Anthem Blue Cross has no obligation and the employer has no right to continue coverage during an employee's short-term medical leave of absence for longer than the period indicated in your group application. After the time period for continued coverage ends, an enrollee may continue coverage under COBRA or Cal-COBRA, as applicable.

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

Benefit modifications

Groups can change their group benefit plan by adding new benefits, changing existing benefits or changing eligibility classifications. Benefit modifications are defined as follows:

- Adding a health, dental, vision or life plan
- Changing to a different health, dental, vision or life plan
- Changing the employer contribution level
- Review of the group's Risk Adjustment Factor (RAF)
- Adding workers' compensation insurance
- Adding part-time employees or dependent coverage
- Changing the group's waiting period

There are specific times when groups can request certain types of benefit changes, including requests for changes that can only be made on your group's anniversary date. Please refer to the "Benefit modification job aid" on page 25 for more information about when you can request certain types of benefit modifications and what documents are required when you submit your request.

Depending on the type of change requested, underwriting may be required. To determine if a change in coverage will require underwriting, please refer to "How to request changes," available at anthem.com/easyrenew. Certain supporting documentation is required to review a request to modify benefits, and it must be complete and accurate before we can process the request. We must receive the completed documentation, including all necessary Anthem Blue Cross forms, within 30 days of the requested effective date. If the benefit modification is approved, our Underwriting department will determine the effective date for the benefit change.

How to request changes

A guide is available at anthem.com/easyrenew to help determine whether underwriting is required for groups that offer a single plan, designated plans or a mix-and-match option. Note that the grid is based on a combination of both benefit and premium design.

Move to:	Premier PPO Plans			PPO Copay Plans			PPO GenRx Plans			Solution PPO Plans			Lumenos HIA+ Plans		Lumenos HSA 100/70 Plans			Lumenos HSA 80/50 Plans			
	Premier PPO \$10 Copay	Premier PPO \$20 Copay	Premier PPO \$30 Copay	PPO 20 Copay	PPO 30 Copay	PPO 40 Copay	25 GenRx	35 GenRx	45 GenRx	Solution 2500	Solution 3500	Solution 5000	Lumenos HIA+ 750	Lumenos HIA+ 500	Lumenos 2000 (100/70)	Lumenos 3000 (100/70)	Lumenos 5000 (100/70)	Lumenos 1500 (80/50)	Lumenos 2500 (80/50)	Lumenos 3500 (80/50)	
Move from:																					
Premier PPO Plans																					
Premier PPO \$10 Copay	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Premier PPO \$20 Copay	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Premier PPO \$30 Copay	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
PPO Copay Plans																					
PPO \$20 Copay	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
PPO \$30 Copay	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
PPO \$40 Copay	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
PPO GenRx Plans																					
PPO \$25 Copay GenRx	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
PPO \$35 Copay GenRx	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
PPO \$45 Copay GenRx	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Solution PPO Plans																					
Solution 2500 PPO	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Solution 3500 PPO	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Solution 5000 PPO	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Lumenos HIA+ Plans																					
Lumenos HIA+ 750	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Lumenos HIA+ 500	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Lumenos HSA 100/70 Plans																					
Lumenos HSA 2000 (100/70)	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Lumenos HSA 3000 (100/70)	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Lumenos HSA 5000 (100/70)	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Lumenos HSA 80/50 Plans																					
Lumenos HSA 1500 (80/50)	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Lumenos HSA 2500 (80/50)	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Lumenos HSA 3500 (80/50)	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Elements Hospital Plans																					
Elements Hospital Preferred	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Elements Hospital Plus	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Elements Hospital	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
EPO Plans																					
High Deductible EPO	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
HMO Plans																					
HMO \$10 100%	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
HMO \$25 100%	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Classic \$20 HMO	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Classic \$30 HMO	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Classic \$40 HMO	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Saver \$20 HMO	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Saver \$30 HMO	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Saver \$40 HMO	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Select \$25 HMO	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Select \$35 HMO	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Additional Plans																					
Advantage 25 PPO	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Lumenos 1500 (100/70)	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
PPO HSA 2400	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
PPO HSA 3500	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
Lumenos HIA+ 3000	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
PHF 750	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
PHF 500	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
PPO Saver	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
PPO Basic	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U

Benefit modification job aid

You can request coverage changes at specific times by submitting the required forms and documentation, which must be accurate and complete. We must receive the required information within **30 days** of the requested effective date. Depending on the change requested, underwriting approval may be required. If the benefit modification is approved, our Underwriting department will determine the effective date for the benefit change. Below is a chart with information about specific types of benefit modifications, eligibility and required documentation.

Requested Change	When Eligible	Required Documents
<p>Add health plan(s) – Increase number of plans offered under existing Anthem Blue Cross health coverage</p> <p>Request upgrade – Change in benefits that requires underwriting. Note: Refer to Employer Plan Change Guide to identify changes that require underwriting. (No rate or benefit guarantee will apply.)</p>	Six months after original effective date, once in a 12-month period	<ol style="list-style-type: none"> 1. Letter from the group 2. Employer Application 3. Change of Coverage applications, for employees changes that require underwriting. 4. Current DE-6 (reconciled) (Subject to underwriting approval)
Request downgrade – Change in benefits that does not require underwriting. Note: Refer to Employer Plan Change Guide to identify changes that require underwriting. (No rate or benefit guarantee will apply.)	Six months after original effective date, once in a 12-month period	Letter from the group (In some circumstances Change of Coverage applications may be required)
Change in employer contribution level	Six months after original effective date, once in a 12-month period	<ol style="list-style-type: none"> 1. Letter from the group 2. Employer Application 3. Change of Coverage applications, for employees requesting a change (subject to underwriting approval)
Add part-time employee eligibility or change part-time coverage from one option to the other (15-29 hours or 20-29 hours per week)	At renewal	<ol style="list-style-type: none"> 1. Letter from the group 2. Employer Application 3. Current DE-6 (reconciled) 4. Employee Applications for all eligible part-time employees
Integrate workers' compensation coverage	First of the month following receipt of all documentation	Call Employers® at 800-520-1683
<p>Add dental and/or vision</p> <p>Add voluntary dental</p> <p>Change dental and/or vision</p> <p>Canceled Blue View vision coverage can be re-added only at anniversary date</p>	First of the month following receipt of all documentation	<ol style="list-style-type: none"> 1. Letter from the group 2. Employer Application 3. Employee Applications for all enrolling employees
<p>Add life insurance or increase existing coverage</p> <p>The following amounts are guaranteed issue (GI):</p> <ul style="list-style-type: none"> \$30,000 for 2-9 enrolled \$50,000 for 10-24 enrolled \$100,000 for 25-50 enrolled <p>Coverage amounts over GI are subject to underwriting approval.</p>	First of the month following receipt of all documentation	<ol style="list-style-type: none"> 1. Letter from the group including contribution amount 2. Life Enrollment and Beneficiary Designation forms for enrollees not currently covered on a Life plan. Employee application may be required to underwrite coverage amounts over guaranteed issue. (subject to underwriting approval)
Change in Risk Adjustment Factor (RAF)	At renewal	<ol style="list-style-type: none"> 1. Letter from the group 2. Current DE-6 (reconciled)

Please note: Letters from the group must be on company letterhead and signed by an owner/officer of the company.

More about group requirements and maintenance

Continuation of coverage

When a member's employment with the group 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.

You are obligated by law and by contract with Anthem Blue Cross 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 Blue Cross.

You are responsible for notifying us in a timely manner about changes in group size that cause changes in the groups Medicare and COBRA status.

Cal-COBRA

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

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 coverage for dependents)
- The employee's employment is terminated, or the employee's hours are reduced
- 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 subscriber becomes eligible for Medicare
- An enrolled family member is no longer eligible

In most cases, the subscriber is responsible for notifying Anthem Blue Cross about a qualifying event within 60 days of the event. When the qualifying event is employment termination or reduced work hours, the employer must notify us within 30 days from the date that the event occurred. Notification must be submitted in writing by completing section 1 of the 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 and dental coverage that was in effect when the subscriber's qualifying event occurred. The subscriber's coverage is subject to the same changes in benefits and premiums that affect the group plan.

We will bill the subscriber directly on a monthly basis for the premium. The subscriber is responsible for paying the premium 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 bill. The employer will not be charged the Cal-COBRA premiums.

COBRA

Participation in the employee's benefit plan, as well as coverage under whatever health programs are provided by the employer to employees and their dependents, may be continued under a federal law known as COBRA for groups that employ 20 or more employees for at least 50% of the previous calendar year. Administration, for the purpose of compliance with COBRA, is the obligation of the employer under this federal law. Anthem Blue Cross is not responsible for COBRA administration. (See Page 34 for information about COBRA administration services offered by Ceridian.) You are responsible for providing satisfactory notice to employees about COBRA benefits, as well as disclosure and other administrative obligations imposed under ERISA.

Eligible former employees have a 60-day election period to decide if they will continue benefits under COBRA. You must complete section 1 of the Small Group 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 Blue Cross will reinstate employee and/or dependent coverage retroactive to the original employment or coverage termination date, without a lapse in coverage.

Under California law, 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 Blue Cross will notify the COBRA member about the option to extend coverage under Cal-COBRA for up to 36 months. This letter will also provide applicable Cal-COBRA rates. The COBRA member must respond, indicating whether he or she wants to extend coverage under Cal-COBRA.

Medicare Part D

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

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

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

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

Note: Anthem Blue Cross and its affiliated companies have been chosen as a provider of Medicare Part D plan options. For more information, your Medicare-eligible employees can contact your group’s authorized independent agent, or they can call our Senior Services department at **866-892-5340**. They can also call Medicare directly at **800-MEDICARE**. TTY/TDD users can call **877-486-2048**, 24 hours a day, seven days a week.

HIPAA

Terminated employees and/or their dependents who have **exhausted** or aren’t eligible for **COBRA** or Cal-COBRA coverage may be able to continue coverage through the Health Insurance Portability and Accountability Act (HIPAA) or the Anthem Blue Cross conversion plan. They can also apply for Individual Anthem Blue Cross coverage.

When advising employees or dependents about their rights to continue coverage under COBRA or Cal-COBRA, please ensure they understand that if they don’t elect COBRA or Cal-COBRA continuation coverage, they will NOT be entitled to the HIPAA guaranteed option.

Conversion

When coverage under the employer plan is terminated, employees can apply to Anthem Blue Cross within 31 days after the termination date for a Conversion Benefit Agreement. The terms, benefits and subscription charges of the conversion plan are different from those of the employer plan. Conversion is not available if the:

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

Application for conversion coverage is available without a completed health statement if there has been no lapse in coverage. The first quarterly premium, accompanied by a completed application, must be submitted to Anthem Blue Cross.

About claims

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.

Coordination with Medicare

Your group's Anthem Blue Cross Small Group plan **does not** provide supplemental coverage to Medicare recipients, but we do coordinate coverage with Medicare. Under TEFRA/DEFRA requirements, an Anthem Blue Cross 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 Blue Cross 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.

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

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

Value-added services for members

360° Health® your total health solution

Anthem 360° Health® is an added value you can trust. Our suite of programs come with tools, resources and support to help your employees improve their health and productivity.

- Online
- Distinctive features include: A holistic look at each member – not just his or her condition – to help improve health and help reduce health care costs

When your employees are healthy, you have a more productive workforce and potentially lower overall health care costs. 360° Health helps achieve this by offering each employee and covered family member the right level of support.

Our 360° Health program includes:

- ConditionCare
- ComplexCare
- MyHealth Advantage
- 24/7 NurseLine
- MyHealth@Anthem
- Future Moms

For more information on the 360 Programs and resources available, please visit anthem.com/ca and click Health and Wellness.

HealthyCheckSM

Anthem Blue Cross PPO plan members, ages 7 through adult, can get convenient annual preventive care screenings through our HealthyCheck centers. Children ages 7-17 receive dental, vision and hearing screenings, along with required childhood immunizations, free of charge. Adult screenings, include a health assessment, lab tests, a personalized health status report and recommendations for possible further evaluation by a doctor.

HealthyCheck participants can access personalized health status reports through our secure, interactive website, which allows members to input and receive updated general health information and advice. HealthyCheck appointments are scheduled within 60 days of a member's request and within 30 miles of a member's home or job. Access to our interactive website at anthem.com/healthycheck allows members to set up a confidential personal health record to keep track of their health status — good for life! Members can receive their individual health status report by mail or register their screening results directly online for an instant report. Either way, their information is confidential. Test results are also sent to the member's doctor of choice. To schedule an appointment at a HealthyCheck center, members can call **800-274-9355**.

BlueCard®

With the BlueCard program, our PPO members who need care when they're traveling can enjoy the benefits of their Anthem Blue Cross membership anywhere in the United States (subject to the terms and payment provisions of their Anthem Blue Cross 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 70% of doctors and 80% of hospitals in America. 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 **800-810-BLUE (2583)**.

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 websites at either anthem.com/easyrenew or at anthem.com/ca.
- **Call Customer Service** — Forms can be faxed or mailed to you (including large-quantity orders) by calling Customer Service at **800-627-8797**.

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.

or email Steve@SteveShorr.com

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 bill (see the **About your billing** section). Premiums must be paid on or before the due date and should be sent with the payment coupon to the address below:

Anthem Blue Cross Life and Health Insurance Company
P.O. Box 54630
Los Angeles, CA 90054-0630

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

Enrolling new employees

An Employee Application must be submitted to enroll a new employee in life insurance (see "Coverage effective dates" in the **Enrollment guidelines** section for information about when we must receive applications). Applicants that apply for coverage and submit their complete, signed enrollment forms within 31 days of their eligibility date will be added as of the original effective date. However, if we receive forms after the 31-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.

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 immediately by submitting a letter of request. Changes related to an increase in life insurance amounts are done annually at your group's anniversary and would impact any and all changes for the entire group that may qualify.

Ending coverage

You are responsible for notifying us about a requested coverage cancellation due to employment termination or other reasons, including death of the employee. Completing a Small Group Information Change Form and fax it to **805-499-0842**. **Please do not submit the Small Group Information Change Form or any correspondence with your premium payment.**

Salary-based plans

If your group has elected life insurance benefits based on salary, you are responsible for providing updated annual base-salary information on all covered employees within 31 days of the employer's anniversary date.

Beneficiary designations

Life insurance coverage requires designating a beneficiary. The employee's designated beneficiary must be indicated on the appropriate form (see the chart on page 31) 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 form indicated on page 31. Any life insurance benefit payment made by Anthem Blue Cross Life and Health Insurance Company under the policy and before we receive such notice will fully discharge 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 websites at either anthem.com/easyrenew or at anthem.com/ca. You may also request that forms be faxed or mailed to you by calling Customer Service at **800-627-8797**.

Desired Action	Form to Use	Notes	Mail to:
Change employee's name or beneficiary designation	Life Enrollment/ Beneficiary Designation	The change won't be effective until we receive the form.	Anthem Blue Cross Life and Health Insurance Company Small Group Services P.O. Box 9062 Oxnard, CA 93031-9062
Request life insurance conversion information	Request for Life Insurance Conversion Information	The employer must provide the completed form to each terminated employee within 31 days of the date the employee becomes ineligible for group life/AD&D insurance due to termination of employment, retirement or any other reason. The employer is responsible for notifying employees about their right to convert life benefits.	Provide the form to the terminated employee, who then must complete and sign the form if he or she wants conversion coverage. The employee then must mail the completed form to: Anthem Blue Cross Life and Health Insurance Company Group Conversion Department P.O. Box 182361 Columbus, OH 43218-2361
Claim death benefits	Beneficiary Claim & Group Policyholder Statement	The employer is 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 724767 Atlanta, GA 31139-1767
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 a named assignee(s), including privileges and rights to beneficiary designation.	
Claim benefits during a terminal illness		The employee completes #3365, Claim for Personal Accelerated Death Benefits. The attending physician completes #3364, Accelerated Death Benefits Physician Statement.	
Claim benefits for dismemberment or loss of an eye		The employer and employee complete form #SM2288 4/09, Accidental Dismemberment or Loss of Sight Claim. The employee's doctor completes #WL2007.	
Claim total disability benefits	Total Disability Claim Form - Waiver of Premium	The employer is 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.
 - The employer must complete the policyholder section of the form and the employee must complete the insured section.
 - We must receive the form within 12 months of the last day the employee worked due to the disability.
- If a death occurs during the period of total disability, a claim must be submitted, whether or not the initial notification of disability was made.

Workers' compensation

Offered by Employers®

Anthem Blue Cross and Employers have teamed to offer a convenient, cost-saving option for integrating health and workers' compensation coverage.

- Save 10% automatically on the workers' compensation portion of your group's integrated monthly billing.
- **You could enjoy more savings** on the health portion if your group qualifies (underwriting is required).

For more information, talk with your Anthem Blue Cross agent or call **800-677-3252**.

How to submit payment

Submit payments to Anthem Blue Cross at the following address:

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

We'll bill you 30 days before your premium due date. Remove the coupon from the bottom of the bill and return it with your payment. Keep the top section for your records. It's important that you pay the exact premium amount shown on your bill.

For groups with workers' compensation coverage, separate spaces are provided on the coupon for the Anthem Blue Cross premium payment and the workers' compensation payment. Please indicate on the coupon how much of your payment is for Anthem Blue Cross and how much is for workers' compensation so we can correctly apply your payment.

Please note that Employers workers' compensation policies and Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company 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 **866-461-2934** or mail written requests to:

Employers
P.O. Box 539004
Henderson, NV 89053

Integrated MediComp savings

All Employers workers' compensation accounts written through our Newbury Park office are eligible to be integrated and are eligible for any premium savings available. Any applicable health savings is subject to underwriting approval.

Workers' compensation is provided under policies issued by Employers Compensation Insurance Company of Nevada.

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 **800-232-3085**.

Health treatment and network kit

When you receive your claims kit, you'll also receive the resource materials you need for directing injured employees to the appropriate health network facilities with arrangements 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 **800-520-1683** or e-mail 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 the workers' compensation benefit, including who's covered, what's 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 the employer, the employee keeps the Employee's Temporary Receipt.

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

Step 4: The employer promptly forwards the "Insurer copy" to Employers. The California Labor Code calls for 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 disability.

Prompt reporting is essential to prompt disability payment. We strongly recommend that you call the Employers 24-hour claims reporting service at **800-232-3085** to report all injuries. If the claim is reported by telephone to this number, it's not necessary to complete the Employer's 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

Offered by Ceridian

Section 125 Premium Only Plan (POP)

To apply for a Section 125 Premium Only Plan, you must submit a completed POP application along with a separate enrollment check (if applicable). POP allows employees to contribute their share of premiums on a pre-tax basis and provides the employer with certain tax advantages. The form is part of the Anthem Blue Cross Employer's Guide to POP, which you can order on the Small Group Supply Request Form or request from your Anthem Blue Cross agent or Membership Services.

FSA and COBRA administration

Flexible Spending Account (FSA) administration services

Ceridian Flexible Spending Accounts (FSAs) are designed to help maximize pre-tax dollars and reduce employer payroll taxes. An FSA allows members to reserve a specific amount from their paychecks on a pre-tax basis each year to help pay for certain health and/or dependent care expenses that aren't covered through their employer 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. Employer tax savings may even offset the entire cost of FSA administration.

When a group signs 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. Ceridian's 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 Ceridian directly at **800-767-4969**. Anthem Blue Cross won't be involved in the enrollment or administration of Ceridian's FSA or COBRA services. All applications will be sent directly to Ceridian, which will be your contact for any account concerns.



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