Anthem

Nevada

Group administrator manual

Small Group employers (1-50)

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

This content is provided solely for informational purposes. It's not intended as and doesn't constitute legal or business advice. The information contained herein shouldn't be relied upon or used as a substitute for consultation with legal, accounting, tax and/or other professional advisors.

65710NVEENABS Rev. 9/24

Thank you for choosing Anthem

Welcome to Anthem. We've created this *Group Administrator Manual* to help you find quick answers about enrollment, billing, membership changes and other day-to-day administrative tasks. We're also available to speak with you one-on-one to answer your questions and help make your day easier! You can always get more help by logging in at anthem.com or calling your Anthem Service team at 1-800-922-4770 (Option Small Group)

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

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

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

We want to make sure that you have access to programs, tools and resources that can help you get the information you need, when you need it. Our purpose is to transform health care with trusted and caring solutions...together. Let's work together to make sure you and your employees can be as healthy as possible and lower health care costs every step of the way.

Register now

To register for EmployerAccess through anthem.com:

1. Visit anthem.com and select **Employers**.
2. Under Support, select **Registration** and follow the prompts to finish. (You'll need your group/case number to complete the process.)

Table of contents

Member maintenance and changes

About your billing

Continuation of coverage

Coordination with Medicare

Helping employees use their benefits

Connecting employees to health and wellness programs that save you money

Offering a whole health solution to positively impact health and costs

Forms and supplies

How to get help

Important contact information

Questions about...	Contact	Phone/Fax/Email/Web	Address/Hours of operation (M-F, unless stated otherwise)
Premiums or billing	Membership	*Off-exchange plans only:* Phone: 1-800-922-4770 Fax: 1-855-750-2227 Email: small.group@anthem.com Web: EmployerAccess	Anthem Blue Cross and Blue Shield P.O. Box 51011 Los Angeles, CA 90051-5311 Hours: 7 a.m. - 4:30 p.m. PT
Enrollment or applications	Membership	*Off-exchange plans only:* Phone: 1-800-922-4770 Fax: 1-855-750-2227 Email: small.group@anthem.com Web: EmployerAccess	Anthem Blue Cross and Blue Shield Small Group Services P.O. Box 172405 Denver, CO 80217-2405 Hours: 7 a.m. - 4:30 p.m. PT
COBRA, HIPAA and/or Medicare	Membership	Phone: 1-800-922-4770 Fax: 1-855-750-2227 Email: small.group@anthem.com Web: EmployerAccess	Anthem Blue Cross and Blue Shield P.O. Box 172405 Denver, CO 80217-2405 Hours: 7 a.m. - 4:30 p.m. PT
Medical claims	Member Services	Phone: 1-855-330-1218 (Off exchange) 1-855-711-8950 (On exchange)	Anthem Blue Cross and Blue Shield P.O. Box 5747 Denver, CO 80217-5747 Hours: 7 a.m. - 8 p.m. PT
Pharmacy (general)	CarelonRx	Phone: 1-833-203-1742	Hours: 24 hours a day, seven days a week
Vision claims (out-of-network only)	Blue View Vision℠ Customer Service	Phone: 1-866-723-0515	Blue View Vision Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111 Hours: Mon. - Sat., 5:30 a.m. - 9 p.m. PT Sun., 9 a.m. - 6 p.m. PT
Coverage while traveling	BlueCard PPO program	Phone: 1-800-810-2583 Web: bcbs.com	Hours: 24 hours a day, seven days a week
Forms and supplies		Web: anthem.com/nv/forms Change state/Nevada	
EmployerAccess	Technical support	Phone: 1-866-755-2680 Fax: 1-888-470-6598 Email: employeraccesssupport@anthem.com	

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

Get instant help with our self-service options

With EmployerAccess, you have password-protected access to real-time information that makes it easy to manage your Anthem account. Our online registration is quick, easy and secure. Log in to your account to stay up-to-date with the latest information and get access to:

Online enrollment

- Enroll new hires
- Manage open enrollment benefits
- Handle membership information maintenance
- Change employee information (such as address or phone number)
- Terminate an employee's and/or their dependent's benefits
- Reinstate employee benefits
- Add dependents to an employee's coverage
- View contract and coverage information (for example, current address, phone number and plan details)
- View employee coverage history from previous years
- Request member ID cards

Online billing

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

Other information

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

Get answers on the go with live chat in the **EmployerAccess** mobile app. You can now get answers on the go from a live agent through the **EmployerAccess** app. Employer live chat in the app has live agents available to help you from 8 a.m. to 5 p.m. local time, Monday through Friday. Just select the chat icon to be connected to the Employer Assistant, then type in "Live Agent" or "Live Chat." Download the **EmployerAccess** app today to view employees, access your group's billing activity, make a one-time payment, and stay connected to the latest news.

Members

Private information is encrypted and only available when accessed with a personal identification number (PIN). Members can:

- Update their personal information, such as address and phone numbers
- Review their plan coverage
- Check the status of a claim
- Find in-network doctors, specialists and hospitals
- Change their primary care physician (PCP)
- Request additional ID cards and print temporary ID cards

Interactive Voice Response system

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

To get started, have your employer case/group number available and call 1-800-922-4770. You'll be prompted to say or enter your information. Then, simply press 1 to get your group administrator options.

Summary of Benefits and Coverage (SBC)

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

This content is provided solely for informational purposes. It isn't intended as and doesn't constitute legal advice. The information contained herein shouldn't be relied upon or used as a substitute for consultation with legal, accounting, tax and/or other professional advisors.

Group rules and requirements - medical

Supplying correct information

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

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

You also must notify Anthem about changes that affect the group. These changes include, but aren't limited to:

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

You must submit information about these and other events within the timeframes that are outlined in your *Combined Evidence of Coverage* and *Disclosure Form/Certificate*.

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

Employee participation requirements

A certain percentage of eligible full-time employees must enroll in the Anthem coverage offered by the employer.

To calculate employee participation:

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

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

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

The result indicates the total number of eligible employees.

3. Then subtract the number of employees who have qualified waivers. Employees who simply choose not to participate are not counted toward qualified waivers.

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

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

	Health coverage
Total employees	**30**
Waive those who don't participate for allowable reasons - Employees with military coverage - Employees covered by spouse's employer group plan - Employees covered by parent's employer group plan - Employees who want to keep existing Individual plan coverage	 -1 -1 -4 -1
Eligible employees	**23**
Subtract those who don't participate for other reasons	-3
Eligible enrolling employees	**20**
Participation percentages	**87%**

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

Product participation requirements

Medical
Standard group participation requirements:

- Minimum 75% of eligible employees

Dental
Dental Essential Choice participation requirements:

- 2-4 eligible requires 100% participation.
- 5-50 eligible requires 75% participation.
- At least five employees must enroll if the group is offering voluntary dental

Vision
Standard group participation requirements:

- Minimum 50% of eligible employees with a minimum of two enrolled when employer offers vision coverage on a stand-alone basis or with health coverage.
- Voluntary vision requires minimum of five enrolled employees.

Dual option participation requirements:

- Requires minimum of 10 net eligible employees. Cannot combine a voluntary vision plan with an employer sponsored vision plan.
- Two or more employees must enroll in each plan option with at least 50% of total eligible employees enrolling
- Voluntary vision requires minimum of five enrolled employees in each plan option.

Employer contribution requirements

Employers can share monthly premium costs with their employees. You choose 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.

Employer contribution options			
Type of coverage	**Traditional** (percentage applied to all plans employees are enrolled in)	**Percentage of plan*** (percentage based on the price of one designated plan only)	**Fixed dollar** (dollar amount applied to all plans employees are enrolled in)
Health	50% to 100%	50% to 100%	A minimum contribution of 50% towards the leanest plan with employee enrollment.***
Dental and Vision	N/A**	N/A	N/A

* The Percentage of plan option is only available for health coverage.
** Employers can offer Voluntary Vision with a minimum of 5 enrolled employees.
*** Certain restrictions apply.

Employer waiting periods

New and renewing groups can't have a waiting period greater than 90 days. You select 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 the employer's benefit plan. Anthem offers first of the month following date of hire, 1-month or 2-month wait periods. The first available effective date for new employees is the first day of the month following or coinciding with the month when the waiting period expires.

You can select two different waiting periods to accommodate various classes of employees in the group, as long as each employee class that is eligible for each type of waiting period is distinctive and clearly defined. When completed Employee Enrollment Applications are submitted, they must include clear instructions about which waiting period applies. Anthem 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 plan and/or 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 employer's request.

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

Group rules and requirements - specialty

Dental Essential Choice coverage

We offer Dental Essential Choice dental plans through our dental company, Anthem Dental.

Enrollment and changes

- Dental Essential Choice dental plans are available for groups of 1-50 with a minimum of two employees enrolling.
- Dual option is available if the group has at least 15 net eligible employees. A minimum of five employees must enroll in each option with a 10% premium differential.
- Dual option isn't available for Voluntary plans.
- Group must be headquartered in Nevada.
- Groups with 50% or more of eligible employees residing outside the state are subject to Underwriting review.
- Cannot accept SIC codes 9999 or 8021 (Dental offices and clinics are not eligible).
- Coordination of benefits applies.
- Stand-alone Dental Essential Choice requires no Nevada Employer's Quarterly Nevada Contribution and Wage Report.
- Medlock feature is available. Enrollment elections for Anthem medical and Anthem dental must be the same (for example: employee only on medical, dental must be employee-only). Medlock doesn't apply to voluntary dental.
- Optional orthodontic coverage is available for employer-paid Classic and Enhanced plans and Voluntary plans:
  - Requires five or more employees to be enrolled.
  - Employer paid: no orthodontic waiting periods for new groups or new hires.
  - Employer paid: coverage options are for child-only orthodontic coverage for dependents age 8 through 18 or adult and child orthodontic coverage from age 8.
  - Voluntary plans have single dependent option, child (age 8-18) only
- Maximum carry-over provision is provision is included on all plans.

Group maintenance and changes

Anniversary dates

Your anniversary date is the month and day when the group's plan and/or policy became effective and coverage started.

Unless specifically authorized by Anthem, the group's anniversary date cannot be changed. The group's anniversary date is important because there are certain actions and changes that can occur only on that date. These activities include the following:

- Change from one type of plan to another type of plan that you already offer
- 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 first of the following month (for example, if the original effective date is January 15 of one year, then the anniversary date is February 1 each year after that).

Changes in ownership

You must notify Anthem in writing about any changes in the company's ownership. The written notice must contain full details, including 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 company's new owner chooses to join the plan, a new underwriting review may be required, which could affect premium rates. Anthem also must be notified if the name of the company or its federal tax ID number changes.

Your group benefit agreement isn't assignable or transferable and it may not, among other things, be transferred as part of a sale of the assets of the business. These changes must be submitted directly to the Small Group Underwriting department at smallgrouprenewals@anthem.com or by fax 1-888-819-7475.

Group address changes

We recommend that you submit company address changes to us in writing. Only the group's authorized representative, broker or the employee can initiate an address change.

Submit an employer address change on an *Employer Application* or on company letterhead with the signature of an owner or officer of the company or group administrator.

Canceling group coverage

If you decide to discontinue the group's coverage, please notify Anthem immediately in writing and, in any event, at least 31 days before the requested cancellation date. Premiums must be paid through the requested cancellation date. The written notice must be on company letterhead and signed by an owner or officer of the company, group administrator or broker of record.

You're responsible for notifying employees in a timely manner when coverage has been canceled.

Termination of group coverage

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

- Material misrepresentation
- Nonpayment of premium
- Failure to meet minimum contribution and/or participation requirements

You're responsible for informing employees when coverage has been terminated.

Benefit modifications

On their anniversary date, groups may make the following changes to their current group health or specialty plans:

- Add or delete plan offerings.
- Change eligibility classifications.
- Request to change portfolio of products.

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

Depending on the type of benefit modification requested, underwriting may be required. 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 forms, at least **31 days** before the requested effective date. If the benefit modification is approved, our underwriting department will determine the effective date for the benefit change.

Benefit modification job aid

The group 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 at least 31 days before 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.

Benefit modification	When eligible	Required documents
Increasing number of plans offered under existing Anthem medical or vision coverage	On anniversary date	1. *Renewal Change Form** (from renewal output) or 2. *Specialty Benefit Modification Form* (for vision)
Change plans or networks	Off anniversary	1. Complete Nevada *Small Group Anniversary Date Change Request Form* Note: By requesting this change a group's anniversary month will change. Employers should consult their tax and legal advisors as this change may impact the group's plan year. Request can only be made six months after the original effective date, once in a 12-month period (on an exception -basis only). New rates and benefits may apply.
Add dental or vision coverage	First of the month following receipt of all documentation	1. *Specialty Benefit Modification Form* 2. Census file or *Employee Enrollment Application* 3. Rate proposal
Dental Essential Choice plans	First of the month following receipt of all documentation	1. *Specialty Benefit Modification Form* 2. Census file or Employee Enrollment Application 3. Rate proposal
Add domestic partner coverage	First of the month following receipt of all documentation	1. Letter from group 2. *Affidavit of Domestic Partnership* from applicant

Benefit modification	When eligible	Required documents
Change in ownership Underwriting will determine if group can maintain current contract or will need to apply as a new group.	First of the month following receipt of all documentation	1. Letter from group 2. Legal documentation to support buyout, sale of assets or merger/acquisition
Change in contribution option	Six months after the original effective date, once in a 12-month period	Letter from group
Change in waiting period	Six months after the original effective date, once in a 12-month period	Letter from group Note: Change will affect future (not current) employees

Please note: Benefit modifications are subject to Underwriting approval. Letters from the group must be on company letterhead and signed by an owner or officer of the company or group administrator.

* All new employees are required to submit a completed *Employee Enrollment Application*. Those already enrolled in the plans may use the *Renewal Change Form.*

Member eligibility rules and requirements

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.

- ***Full time -*** A full-time employee must be actively engaged in the conduct of the employer's 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 1099 or a W-2 form are eligible for enrollment. Employees compensated on a 1099 basis may be eligible for coverage, but restrictions do apply. Please contact your authorized Anthem agent for additional information.
- ***Sole proprietors*/partners/corporate officers -*** Sole proprietors, partners and corporate officers must be actively engaged in the conduct of the business on a full-time basis, with a normal schedule of at least 30 hours per week.

Employees living outside of Nevada

At least 50% of enrolled employees must reside in Nevada. Or at least 50% of the enrolled employees must reside in an Anthem defined service area if the highest number or equal to the highest number of enrolled employees reside in Nevada.

Important note: Plans for employees residing in other states may be different than for employees residing in Nevada. Some plans are only available to employees who reside in the areas of Nevada served by the Pathway preferred provider organization (PPO) and health maintenance organization (HMO) networks. Contact your agent or our Membership department for more information.

Residents of Hawaii

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

Ineligible employees

Part-time, temporary, substitute, contract, leased, retired and seasonal (defined as "employees hired with a planned future termination date") employees aren't eligible for group health coverage.

Eligible dependents

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

- Lawful spouse.
- Any biological or legally adopted child of the subscriber or the subscriber's enrolled spouse, up to age 26.
- A stepchild of the subscriber or the subscriber's enrolled spouse.
- A child (ward) of the subscriber's enrolled spouse who is named the ward's permanent legal guardian.

*Sole Proprietors aren't eligible for small group coverage as of January 1, 2014 (new groups only).

- Grandchildren, if the grandparent:
  - Is enrolled under the group's plan.
  - Is a permanent legal guardian of the grandchild.
  - Has proof of guardianship.
- The domestic partner (includes same-sex partner) of the of the subscriber is eligible for health care benefits. However, an employer may choose not to offer the eligibility. Any current employee who would like to add a domestic partner must complete an *Affidavit of Domestic Partnership* and include it with an *Employee Enrollment Application*.
- Other such classifications as required by law or regulation.

Over-age dependents

The health care reform law allows an employee's children to remain covered on their health plan until they turn 26 years old, making the maximum dependent age 26 under the federal law. If the law in your state provides for a higher maximum dependent age, that requirement will continue to apply.

To be eligible for this coverage, children don't need to be:

- Financially dependent on the member for support.
- Claimed as dependents on the member's tax return.
- Enrolled as students.
- Unmarried.

Spouses of children and grandchildren aren't eligible (unless certain eligibility criteria are met). "Children" are defined as natural children, legally adopted children, stepchildren and children who are dependent during the waiting period before adoption.

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

If the requested coverage is due to a court order: 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. Anthem will determine if the child meets the criteria for coverage. An application for coverage must be submitted to Anthem within 31 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 other prior coverage with Anthem coverage: We will request information that the child meets the applicable coverage criteria. 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.

Leaves of absence

Short-term personal leave of absence

You determine the length of time, up to three months, that health benefits will remain in effect under the plan if an employee takes a short-term personal leave of absence. If you approve the leave, enrolled employees are eligible to continue group coverage for themselves and their enrolled dependents for the period of time.

Monthly premiums will continue to accrue during an employee's short-term personal leave of absence, and you must continue to pay the required monthly premiums. However, you can request that the employee pay the premiums directly to you during this period.

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

Enrollment guidelines

Enrolling new employees

We recommend that you submit an application immediately after an employee is hired. Coverage won't begin before the applicable waiting period is over.

The preferred method of enrolling employees and their dependents (if applicable) is online through EmployerAccess. When you enroll new employees online, Anthem doesn't require any paperwork from the group! Please note, you should always keep signed employee applications on file in case Anthem should need them for legal reference.

For Anthem to enroll your employee or their dependents, the employee must complete an *Employee Enrollment Application*. We must get the completed application after the employee's date of hire and before the last day of the month in which the employee is eligible.

Please note that there are no exceptions to these requirements. Incomplete applications won't be processed, which may delay the 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 may not be eligible for coverage until the next open enrollment period without a qualifying event, depending on the plan. (See *Open enrollment/Late enrollees*).

The employer must make sure that sections A - G of the *Employee Enrollment Application* are completed for any employees and/or eligible dependents who decline coverage. As explained in the Evidence of Coverage, late entrants may be subjected to a delayed effective date of coverage.

Important note: The employer is responsible for ensuring that an application for each eligible employee who is applying for or declining coverage is forwarded to Anthem in a timely manner. Failure to do so will delay coverage for an employee, which may expose the employer to liability to the employee and Anthem.

Enrolling eligible dependents

Type of dependent	Application for coverage or declining coverage must be received:	Must include (if requesting coverage):
New spouse Coverage will begin on the date of marriage.	Within 31 days of new marriage	*Employee Enrollment Application*
Newborn child Coverage of newborns is automatic **only** for the first 31 days following birth. Employees must request to enroll newborns. This needs to be done by completing an ***Employee Enrollment Application*** **within** the first 31 days following birth. **Otherwise, coverage terminates at the end of the 31-day period.** Payment of claims for birth-related expenses isn't an indication of continued coverage. The employee must request the addition of a new dependent.	Within 31 days of birth	*Employee Enrollment Application* (subject to late entrant guidelines)
Adopted child A child who is in the process of being adopted is considered a legally adopted child if Anthem receives legal evidence of intent to adopt or notification of physical custody. In this case, the subscriber or spouse has the authority to control the health care needs of the child or has assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption.	Within 31 days of adoption or the right to control health care	*Employee Enrollment Application* Legal evidence of authority to control the health care needs of the child

Type of dependent	Application for coverage or declining coverage must be received:	Must include (if requesting coverage):
Stepchild A child of the subscriber's spouse	Within 31 days of marriage or qualifying event	*Employee Enrollment Application*
Ward of a permanent legal guardian An unmarried child (ward) of a subscriber or the subscriber's enrolled spouse 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 Enrollment Application* *Letter of Guardianship* form from the court, showing the filing date and court seal
Enrollees under Medicaid or the Children's Health Insurance Program Subscribers and dependents may enroll under Anthem coverage if the subscriber's or dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, or the subscriber or dependent becomes eligible for a subsidy (state premium assistance program). If the subscriber doesn't enroll themselves and/or their dependents when first eligible or during a special enrollment period, they won't be eligible to enroll until the next open enrollment period.	Within 60 days of qualifying event	*Employee Enrollment Application*
All other dependents losing coverage	Within 31 days of qualifying event	*Employee Enrollment Application*
Grandchild(ren) With proof of permanent legal guardianship or adoption.	Within 31 days of issuance of the final court decree or order of legal guardianship	*Employee Enrollment 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 isn't requested within the required time frame: ° 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 depending on the plan, the effective date of coverage may be delayed until the next open enrollment or group anniversary date.	During the group's open enrollment period (Anthem anniversary) Before conditions that would otherwise cause a dependent to be a late enrollee	*Employee Enrollment Application* Proof of qualifying event
Domestic partner (if employer has elected this option) Coverage will begin on the first day of the month following our receipt of documentation. A copy of the *Anthem Affidavit of Domestic Partnership* is required.	Within 31 days of the signature on the *Affidavit*	*Employee Enrollment Application* *Anthem Affidavit of Domestic Partnership*

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 the fully completed application within the eligibility time frames mentioned above.

The member/dependent coverage may be delayed and in some cases, denied if the completed *Employee Enrollment Application* isn't received within applicable time frames.

Enrolling rehired employees

If an enrollee's employment ends and the employee is later rehired, certain restrictions apply. If the employee is rehired **within** 31 days of termination, coverage will resume with no lapse upon our receipt of a written request from the employer group.

If rehire date is within 32-92 days of lay-off or termination of employment, the waiting period will be waived and the employee will be effective the date of rehire.

If the employee is rehired after 92 days, the employee is considered a new employee, subject to applicable waiting periods and must complete a new *Employee Enrollment Application*.

The group is responsible for notifying us immediately if an employee is rehired and will be continuing coverage.

Coverage effective dates

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

- The date of hire
- A waiting period
- Late enrollee classification, as defined under the Health Insurance Portability and Accountability Act (HIPAA)
- The date we receive the fully completed application

Effective dates are determined as follows:

- **Example 1:** If we receive the fully completed application before the employee's waiting period is over, the effective date will be the first day of the month following application approval and waiting period.
- **Example 2:** If we receive the fully completed application after the employee's eligibility date, but within 31 days of the date when the employee becomes eligible, the effective date will be the first of the month following the completion of the waiting period.
- **Example 3:** 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 applicant's effective date may be delayed until the next open enrollment or group anniversary date. See the Evidence of Coverage/Certificate for additional details.
- Please note that all late enrollees will have to be enrolled during the group's open enrollment unless they have a qualifying event as defined under HIPAA.

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.

Minimum essential coverage

The individual shared responsibility provision of the Affordable Care Act (ACA or health care reform law) says that every person has to have basic health insurance coverage or face a penalty. This is known as Minimum Essential Coverage (MEC).

Types of insurance that count as MEC are plans offered by an employer, COBRA coverage, retiree coverage, Medicare, Medicaid, Children's Health Insurance Program (CHIP) and health insurance a person buys from an insurance company direct, through the Health Insurance Marketplace or through a student health plan.

What we require on applications

To make sure people have MEC, the Internal Revenue Service (IRS) needs reports to be sent by those who provide MEC. This is called Minimum Essential Coverage Reporting, or IRS Code Section 6055 Reporting.

We will ask members of fully insured groups for the Social Security number for themselves and covered dependents.

We will also ask people with our fully insured individual coverage for their and their dependents' Social Security numbers, except if they have coverage through the exchange. Self-funded (ASO) groups are responsible for getting the Social Security numbers from workers and their dependents.

Examples of effective dates for eligible employees

	Example 1 Employee submits application within the timeframe	Example 2 Employee submits application after eligibility date (within 31 days)	Example 3 Employee submits application more than 31 days after eligibility date
Hire date	April 3, 2023	April 3, 2023	April 3, 2023
Eligibility date (two-month waiting period)	June 3, 2023	June 3, 2023	June 3, 2023
Completed application received	June 1, 2023	June 30, 2023	September 2, 2023
Effective date	July 1, 2023	July 1, 2023	Employee is eligible on the group's next open enrollment date, which equals the group's anniversary date. The group must submit an application for the late enrollee at the group's anniversary enrollment period.

Examples of effective dates for eligible employees who decline coverage

	Example 1 No qualifying event	Example 2 Employee who experiences a qualifying event
Hire date	April 3, 2023	April 3, 2023
Eligibility date (two-month waiting period)	June 3, 2023	June 3, 2023
Effective date	July 1, 2023	July 1, 2023
Completed application received	July 15, 2023	September 2, 2023
Declination of coverage received	July 15, 2023	July 15, 2023
Employer anniversary	March 1, 2023	March 1, 2023
Date of qualifying event	N/A	September 15, 2023
Completed application received	March 5, 2024	September 20, 2023
Effective date	March 1, 2024 (Open enrollment)	In most cases, the effective date will be the date of the qualifying event.

Employees who decline coverage

New employees who don't elect coverage or existing employees who choose to discontinue coverage under the employer's Anthem Small Group plan and/or policy must complete sections B and F of the *Employee Enrollment Application*.

We must receive the application after the hire date and before the last day of the month following the end of the waiting period selected by the group. The employer is responsible for ensuring that Anthem receives applications from employees who are declining coverage within the same time frame as applications from employees who are requesting coverage. (See *Enrolling new employees*.)

Depending on why an employee chooses to 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 didn't previously receive an application declining coverage, the employee may be considered a late enrollee and be subject to late enrollee guidelines.

Open enrollment

After initial enrollment, employees can make changes to benefit elections at open enrollment. During open enrollment, employees or eligible dependents must submit an Employee Enrollment Application no later than the last day of the group's anniversary month.

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

Late enrollees

If Anthem receives a new *Employee Enrollment Application* more than 31 days after the applicant becomes eligible, the subscriber and eligible dependents will be considered late enrollees and may be subject to delayed effective dates.

Late entrants under medical, dental and vision plans may enroll only during the employer's annual renewal enrollment period. This is known as open enrollment. See *Open enrollment* earlier in this section.

Choosing a PCP

Each applicant, including each dependent, must select a primary care physician (PCP). The corresponding provider number for each PCP selected must be entered on the *Employee Enrollment Application*, the WGS enrollment census tool, the electronic 834 file, the electronic Anthem proprietary file or EmployerAccess. If a PCP isn't indicated on one of these enrollment options, we'll assign one. Members can change a PCP online at anthem.com or by calling the Member Services number on their health plan ID card.

To find a provider number, please follow these instructions:

1. Go to anthem.com.
2. Select Find Care at the top of the page.
3. Click on Search by Selecting a Plan or Network.
4. Use the drop downs to select the type of coverage, state and network.
5. Select Continue.
6. Use the drop downs to select the professional area of expertise and specialty.
7. Enter your zip code (or the zip code from which you want to choose your doctor from).
8. Check accepting new patients and able to serve as PCP.
9. Select Search.
10. Select the doctor you wish to choose as your primary care physician.
11. The PCP ID is located below the doctor's name after you select him/her.

Please note that PCP ID's vary based on network; the same doctor may have a different ID for each network. PCP assignments can only be updated for members living in Nevada.

Employee application tips

- Use black 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 care physician (PCP) is required.
- All requests for information must be completed and returned promptly. Coverage may be denied if we don't receive the *Employee Enrollment Application* within applicable time frames.
- 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).
- **Incomplete applications may be returned, which will delay the coverage effective date.**

Where to submit applications

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

Online:	Enroll employees through EmployerAccess
By email:	small.group@anthem.com
By mail:	Anthem Blue Cross and Blue Shield Small Group Services P.O. Box 172405 Denver, CO 80217-2405
By fax:	1-855-750-2227

Enrollment actions guide

	How this action can be done			
	Electronic	Paper		
Action	EmployerAccess	Employer Application	Employee Enrollment Application	Comments
Add a **new** employee and/or dependents to the plan	✓		✓	Additional documentation may be needed, depending on the type of dependent.
Add dependents for an **existing** employee	✓		✓	
Decline coverage for an employee and/or dependents (Waive)			✓	Section F of the Nevada *Employee Enrollment Application* must be completed.
Change plans for employees or dependents who already have coverage			✓	Changes can only be requested on the group's anniversary date.
Terminate an employee and/or dependents from the plan	✓		✓	Notify Anthem immediately upon termination.
Discontinue coverage for employees and/or dependents who still remain eligible under the plan	✓		✓	An *Employee Enrollment Application* must be completed to avoid delays if coverage is selected at a later date.
Change an employee's address	✓		✓	The employee can also call Member Services directly to make this change.
Notify us about a COBRA qualifying event for an employee and/or dependents already enrolled in the plan			✓	You must complete the COBRA application; which is a different application than the active *Employee Enrollment Application.* Visit anthem.com to save or print a COBRA application.
Remove a subscriber from COBRA	✓		✓	Notify Anthem immediately upon termination.
Change the employer's address		✓		You can also submit a written request on your letterhead, signed by an owner/officer of the company

Important note about Internet capabilities:

For your protection, registration is required in EmployerAccess in order to use certain online features marked in the Electronic column above. Registration is quick and easy and gives you convenient, password-protected access for administering your group account. See *How to get help* for details.

Member maintenance and changes

EmployerAccess is the easiest and fastest way to complete these membership changes for your employees. Registration is quick and easy and gives you convenient, password-protected access for administering your group account.

Changing employee information

We recommend that you submit employee address changes to us in writing. Only the group's authorized representative, broker or the employee can initiate an address change.

Please submit employee address changes on an *Employee Enrollment Application*.

You can also submit address changes online through EmployerAccess. (If you haven't registered for EmployerAccess, please call us at 1-800-922-4770 for details.) Please note that address changes may affect the available plan selections and current rates, so it's important to notify Anthem about these changes in a timely manner. And although we recommend that you submit employee address changes in writing or online.

Canceling employees from the plan

Use the *Employee Enrollment Application* or send the request on company letterhead to cancel the employee. Employees may be canceled due to termination of employment, ineligibility for coverage under the plan, or when the employee wants to discontinue coverage regardless of his/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 a part-time employee.
- An employee is on a leave of absence (medical and/or personal) and the time period that the employer covers employees on leave has expired.
- An eligible employee becomes a temporary, substitute, leased or contract employee.
- An employee otherwise becomes ineligible to participate in the plan.
- The employee no longer wants to continue federal COBRA coverage, or fails to pay the premium.

Canceling terminated employees

When eligibility changes, including terminations, are completed online, Anthem doesn't require any paperwork though we do suggest that you keep all employee applications on file in case Anthem needs them for legal reference.

For Anthem to cancel a terminated employee (employees that aren't termed using EmployerAccess.), please fill out an application or send your request in writing. Please send the termination when it occurs. If the member or dependent is eligible and requests continuing coverage in COBRA, please forward the completed COBRA application to Anthem.

Here's how you can submit both terminations and subsequent applications for continuing coverage:

Online:	Just go to EmployerAccess.
By fax:	1-855-750-2227
By email:	small.group@anthem.com
By mail:	Anthem Blue Cross and Blue Shield Small Group Services P.O. Box 172405 Denver, CO 80217-2405

Please don't include 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. Cancellation 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 doesn't extend beyond the month when the termination occurred and to comply with 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: When a member's employment is terminated, the employee must be canceled from the group.

After Anthem 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 to notify employees of their cancellation of coverage and of any rights to continue coverage. Failure to do so exposes the employer to liability to the employee and to Anthem.**

When preparing your monthly premium payment, please don't delete any premiums for canceled members. A credit for the cancellation will be reflected on a future billing.

Canceling employees who remain eligible but discontinue coverage

Please indicate the following information in a request:

- ID number
- Employee and/or dependent names
- Which coverage is being canceled
- The reason for coverage cancellation
- The effective date

Please remember that the declination section of the Employee Enrollment Application must be completed for those employees who are still employed but canceling coverage.

The employer must provide written instructions and submit it with the *Employee Enrollment Application* to Anthem. Cancellation of the employee's coverage will be effective as of 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 discontinue coverage may be considered a late enrollee if they want to re-enroll for coverage at a later date. If that occurs, the coverage effective date may be delayed until the group's anniversary date. The employee would have to reapply at that time.

Advance premium tax credit (APTC)

An individual who becomes eligible for the APTC (whether due to a change in income, moving to a different state or being ineligible under an employer-sponsored plan) may be entitled to a special enrollment period in which to enroll in a qualified individual health plan offered through the Exchange. While this isn't a qualifying event allowing the individual to enroll in the employer-sponsored plan, it may allow the individual to enroll in a plan offered through the Exchange. Employers must inform terminating employees who may be eligible for the APTC of this possible coverage option and special enrollment period.

Extension of benefits

The plan provides for a limited extension of benefits if coverage ends when the member is totally disabled and certain other criteria are met. The extension (up to 11 months) covers only totally disabling conditions. It is subject to review every three months. An extension of benefits must be requested in writing or by calling our Customer Service department within 90 days of the cancellation of coverage. (See *Continuation of coverage* for more information.) This extension of benefits applies to COBRA-eligible groups only.

Employees turning 65

Medicare is the primary payer for employees age 65 or older in employer groups with fewer than 20 employees. (See the *Coordination with Medicare* section.) Anthem isn't a supplement to Medicare.

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

About your billing

Billing cycle and premium payments

You'll receive an itemized monthly bill from Anthem about one month before the bill's due date. (For example, the bill for May will be sent on April 1. The payment is due May 1.) The bill will include:

- Due date
- Total premium due
- Any past due amounts

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

To work with you more efficiently, we moved away from a paper-based system of invoicing groups and accepting payments. Anthem will issue your group billing statements and receive payments online through our EmployerAccess portal. The group will receive an itemized monthly bill from Anthem about one month before the bill due date.

It's the group's responsibility to make sure the bill is correct every month. If you find something wrong, please call Anthem right away at 1-800-922-4770. We require full payment of the premium listed on the bill.

If you still need to receive a paper bill, we can help you with that, too. Send an email with "Opt Out" in the subject line to: employeraccesssupport@anthem.com. Provide your group number, contact name, email address, phone number and reason for opting out of electronic billing. **Once your "Opt Out" request is processed, you'll continue to receive monthly paper invoices. Be sure to include the group number as it appears on the billing statement to avoid a late payment.**

Some things to keep in mind:

- If we don't receive your payment by the due date, your group plan and/or policy can be terminated.
- All checks must include the group number as it appears on the billing statement. Payment is delayed when the group number isn't listed on the check.
- There's no need to send separate checks for each of your group's products.
- Make sure to mail the payment early enough so it is received by the due date.
- Paying online by the due date reduces the risk for the group being canceled for non-payment of premium.
- When you use EmployerAccess to pay your bill online, payment is posted within one to two days during the business week.

Notification when bill is ready

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

Options for making your payment

Pay online

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

There is no fee for making payments online and payments only take one to two business days to post. Simply register for EmployerAccess to make a one-time payment and/or schedule future payments. Need more details, visit EmployerAccess or call us at 1-800-922-4770.

EmployerAccess is a great way to pay your premiums online. Log in to EmployerAccess (accessible via our Employer Portal) and set up your ePayments on the "*billing*" tab. It takes just a few minutes to pay your premium when you choose "*pay online now*." Plus, it's free and secure.

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

Pay with check by mail

Mail your check and the coupon only to the lockbox address on your bill.

There is no overnight address for premium payments. Credit card payments aren't currently accepted.

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

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

Please note: This is a lock box arrangement, which means that checks are automatically deposited. **Deposit of the check isn't an acceptance of the payment or a guarantee of coverage.**

Pay with check by phone

You can also call 1-855-886-6160 and pay by phone from your checking or savings account. It takes 2-3 business days for phone payments to post. Payment must be posted to the account by the last day of the grace period.

Adjustments to your bill – employee/dependent additions and deletions

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

Please don't adjust your premium payment with credit for deleted employees. Pay your premium as billed. Payments not made "in full" will subject your account to termination. We strongly suggest that you submit deletions to us as they happen, so they're processed timely. Failure to submit eligibility change information in a timely manner could result in premium inaccuracies that you and/or your employees may not be able to recover. Credit for terminations will show on your next scheduled billing statement after we've processed the deletions.

Important note: Please don't submit termination(s) with your premium payment. Terminations won't be processed because they will go to the premium payment lockbox, not directly to Anthem. Instead, please send terminations to the following address:

Anthem Blue Cross and Blue Shield
Small Group Services
P.O. Box 172405
Denver, CO 80217-2405

You can also fax them to 1-855-750-2227, or email small.group@anthem.com or process via EmployerAccess.

Failing to pay your premium or submitting membership changes by marking your bill doesn't meet the notification requirements for terminating an employee or dependent from your plan and/or policy.

Nonpayment of premiums

Nonpayment of premiums could cause your group coverage to be canceled. In that case, the cancellation date will be the last day premiums were paid. Premiums must be paid during your group's final month of coverage. Failure to make your premium payment doesn't meet the notification requirements for canceling your Small Group coverage. See *Canceling group coverage* for information about how to cancel your Small Group coverage. If reinstatement is approved, you will be required to sign up for automatic recurring payments through EmployerAccess. Exceptions must be approved by Anthem.

Premiums are due on the first of the month and the payment grace period ends 31 calendar days from the first day of the month. Claims won't be paid by Anthem until the group premium is paid in full for the month.

Note: See your group contract for more details.

Continuation of coverage

When a subscriber's employment with your company ends, you must cancel the employee as an active employee. If the terminated employee is eligible for COBRA coverage and later selects one of these options within guidelines prescribed by law, we'll re-enroll the individual in COBRA coverage.

You're obligated by law and by contract with Anthem to notify employees of termination of coverage and of any rights to continue coverage. Failure to do so may expose the employer to liability.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Employees whose employment has terminated may continue to participate in the employer's benefit plan, as well as in whatever health care plans you provide to employees and their dependents, under a federal law known as COBRA for groups that employ 20 or more employees for at least 50% of the previous calendar year. For the purposes of COBRA compliance, you are responsible for COBRA administration under this federal law. Anthem isn't responsible for COBRA administration. You are responsible for providing satisfactory notice to employees about COBRA benefits, as well as disclosure and other administrative obligations imposed under the Employee Retirement Income Security Act of 1974 (ERISA).

Eligible former employees have 60 days from the date of termination to decide if they will continue benefits under COBRA. Use the COBRA application to enroll an employee and if applicable, their dependent(s). Please note the periods of notification and election as stated by law.

COBRA-eligible dependents

If a dependent becomes eligible for COBRA, please complete the COBRA application and submit it to Anthem. 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're responsible for notifying Anthem in a timely manner about changes in group size that cause changes in the group's Medicare and /or COBRA status.

Canceling COBRA members

The premium for COBRA can't be more than 102% of the premium charged for employees with similar coverage, and it must be paid to the company's benefit plan administrator within 30 days of the date due, except that the initial premium payment must be made before 45 days after the initial election for continuation coverage, or COBRA continuation rights will be forfeited. After the initial payment, COBRA members are subject to the same grace period as the group. You're responsible for canceling COBRA members in a timely manner if payment isn't received within the specified grace period. **We don't accept retroactive cancellations beyond the original grace period.**

Health Insurance Portability and Accountability Act (HIPAA)

Terminated or active employees or their dependents who have exhausted or aren't eligible for COBRA coverage may be able to continue coverage with one of Anthem's individual off-exchange plans.

When advising an employee or dependent of his or her rights to continue coverage under COBRA,you must ensure the employee or dependent understands that, once continuing coverage is exhausted, the former employee and dependents can apply for an individual off-exchange plan.

You are responsible for informing eligible employees and their dependents of the conversion option. Members must request conversion coverage within 31 days of becoming ineligible or exhausting previous coverage.

Coverage after COBRA coverage ends

When COBRA coverage under the employer plan is terminated, employees may apply to Anthem for an off-exchange plan within 31 days of the termination date.

Coordination with Medicare

Coordination with Medicare

Your group's Anthem Small Group plan **doesn't** provide supplemental coverage to Medicare recipients, but we do coordinate coverage with Medicare. Under The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)/Deficit Reduction Act of 1984 (DEFRA) requirements, an Anthem medical plan is the primary payer for businesses with 20 or more employees, regardless of how many enrollees are covered under the plan. For groups with fewer than 20 employees, Anthem is the secondary payer to Medicare and doesn't duplicate benefits that might be available under Medicare. Anthem determines its benefits, subtracts them from the benefits that are paid or payable under Medicare and pays the difference. Anthem is the primary payer when a group employs more than 100 employees and the Medicare recipient is incapacitated and under age 65.

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

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

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

Medicare Part D

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

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

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

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

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

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

Medicare, Medicaid and State Children's Health Insurance Plan Extension Act of 2007

As your insurer or plan administrator, we are required by law to report member and group eligibility data to the CMS. This information helps both CMS and us determine Medicare primary and secondary responsibilities and pay claims on an accurate and timely basis.

We need to work together in order to meet the obligations under the Medicare Secondary Payer-Mandatory Insurer Reporting (MSP-MRP) requirement of Section 111 of the Medicare, Medicaid and State Children's Health Insurance Plan Extension Act of 2007 (MMSEA).

Please provide us with the necessary information for each enrolled member (subscriber, spouse and domestic partner, if applicable). With this information, we will be better able to comply in accordance to CMS timelines.

Please note: If your group has fewer than 20 full-time or part-time employees and isn't part of a multi-employer group health plan, we don't need any information from you at this time. We will contact you directly if this information becomes required in the future.

CMS provides the following guidance on how to determine your group size. An employer is considered to employ 20 or more full- or part-time employees if the employer has 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year. Group size isn't the number of covered lives under a group health plan.

Additional information

For more information on the requirements, please refer to the CMS website at cms.gov. Choose **Medicare** at the top and click **Mandatory Insurer Reporting For Group Health Plans** under Coordination of Benefits & Recovery.

What you need to provide

To help us meet reporting obligations under this mandate, please provide the following information:

- **Member eligibility data** (as indicated on the *Employee Enrollment Application*)
  - Social Security numbers (SSNs) and/or Health Insurance Claim number (HICN) for all active subscribers
  - SSNs for all spouses or domestic partners and dependent children regardless of age
- **Group eligibility data** (as indicated on the *Employer Application*)
  - Valid group size
  - Valid group Tax Identification or Employer Identification number (TIN/EIN)*

How to submit your data

In order to safeguard the sensitive and confidential member information, your submission of the requested data must be sent to us in a secure manner. While some suggestions are stated below, your company remains, as always, responsible for the security of data in transit to us.

Email submissions

For a secure transmittal of information to us via email, we provide the use of our secure email (messages.anthemsecureemail.com). You will go through a one-time account creation process to create an account with a personalized username and password.

Once you do, you can use the site — messages.anthemsecureemail.com — to create an email with the completed information and submit your group and/or member eligibility data to your enrollment contact in a secure manner. Please send your information to small.group@anthem.com.

Tape/electronic submissions

If you currently provide eligibility data via tape/electronic transfer, please include subscriber, spouse and domestic partner SSNs/HICNs on your existing files.

Paper submissions

If you prefer to mail your eligibility data to us, please capture the required data fields (SSN's, HCIN's) in an Employee Enrollment Application. Due to the sensitivity of the data, we encourage you to take the necessary precautions to secure and protect your information. We suggest that you use a mail vendor with tracking mechanisms in place when sending your data.

*Member and group eligibility data is needed in preparation for CMS mandatory reporting.

Helping employees use their benefits

ID cards and Evidence of Coverage/certificates

All enrolled employees will receive a *Combined Evidence of Coverage* and *Disclosure Form/Certificate* and Anthem member ID cards. If these items are sent directly to you, you're responsible for distributing them to the enrolled employees.

Employees will receive ID cards that show their name and the coverage selected. ID cards aren't automatically generated for each dependent. **Legacy PPO plan members will receive ID cards that list only the employee's name, even if other family members have coverage. For Legacy HMO plan members, if an employee's spouse or dependents choose a different PCP than the employee, we'll issue a separate ID card that shows the spouse's or dependent's PCP.** Affordable Care Act (ACA) plan members (both PPO and HMO) will receive separate ID cards for each dependent. This card is valid for all of the employee's covered family members.

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

Health care 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.

Connecting employees to health and wellness programs that save you money

Lower costs, higher productivity

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

Guide for a healthier lifestyle

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

Health management and coordination

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

Cost-effective resources and tools

- *anthem.com* — Our digital home is more than just a website. It's a health hub for your employees. Here, they can access their benefits, request ID cards, sign up for email messages from Anthem, find in-network doctors, hospitals and other health care professionals that will save them money. They can estimate the cost of medical procedures and see which doctors have the highest performance and safety ratings. It's all about getting your employees healthier so they can go back to work faster.
- *Sydney* — Encourage employees to download our Sydney app to their smartphones to get instant access to their ID card and health record, view claims, find providers, fill prescriptions and more.
- *SpecialOffers* — Discounts on health-related products and services, such as stop smoking programs, fitness club memberships and more to help employees live a healthier lifestyle.
- *AudioHealth Library* — Access to more than 400 health topics by phone to keep employees informed about their health.

For more information on the health and wellness programs and resources available, members should login to anthem.com and select **Health & Wellness Center** under **Care**.

BlueCard PPO program

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

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

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

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

Offering a whole health solution to positively impact health and costs

An overview of comprehensive coverage

You can build a health care coverage package that meets your needs and gives your employees peace of mind.

- **Medical** — start with a strong foundation
- **Dental** — add even more value
- **Vision** — build a clearly superior benefits package

Medical coverage

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

Standard employee participation and employer contribution requirements apply, with a number of plans to choose from and the flexibility for future changes.

- A distinctive mix of PPO, Pathway PPO, Choice PPO, Pathway HMO and Guided Access HMO plans, so you can find the ideal balance between cost and benefits.
- Integrated billing and customer service that make it easy to offer as many plans and types of coverage as you want.

Dental coverage

By offering Dental Essential Choice coverage, you add value to your employees' benefits package.

- ***Integration —*** Members who are pregnant or living with diabetes can get one extra dental cleaning or periodontal checkup each year.
- ***Network —*** Access to one of the largest dental preferred provider organization (PPO) networks in the country, allowing employees to find the dentist they prefer to see.
- ***Additional features —*** Our plans include these unique member features:
  - 100% in-network preventive care to keep employees healthier and more productive
  - Discounts beyond a yearly maximum
  - Wide range of yearly maximum options including a yearly maximum carryover
  - Variety of plan designs
  - Orthodontia options available for groups with 5+ enrolling subscribers
  - A benefit for a brush biopsy to help diagnose cancer in time for treatment
- ***Service —*** With more than 40 years of dental administration experience, the consistency of our U.S.-based customer service operations exceeds service standards.

Vision coverage

With Blue View Vision℠, you can offer a cost-effective, comprehensive plan to meet your employees' vision needs. Flexible financing allows you to set your monthly employer contribution.

Our Blue View Vision plans include:

- Comprehensive eye exams.
- Fast delivery of eyewear.
- A statewide network that includes a big selection of optometrists and ophthalmologists, as well as retail locations such as 1-800 CONTACTS®, LensCrafters®, Pearle Vision®, Target Optical® and separate companies offering vision-related services.
- Retail savings of 15% to 40% (beyond plan benefits) on unlimited purchases of extra pairs of eyewear, nonprescription sunglasses and other popular accessories.
- Customer service hours among the best in the industry.

A minimum of two enrolled employees is required.

- Voluntary vision requires minimum of five enrolled employees.

Forms and supplies

Downloading, requesting and ordering forms

Go online — View and print forms from our website at **anthem.com**/nv/forms.

Glossary

Certificate

This summarizes the terms of the member's benefits. It's attached to and is a part of the group's contract. It's subject to the terms of the group's contract.

Coinsurance

This is a percentage of an eligible expense that the member is required to pay for a covered service.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

A federal act that requires certain group health plans to allow certain employees and dependents to continue their group coverage for a stated period of time. This period of time follows a qualifying event that causes the loss of group health coverage. Qualifying events include reduced work hours, death or divorce of a covered employee and termination of employment.

Deductible

The dollar amount of covered services listed in the Schedule of Benefits for which the member is responsible.

Dependent

A Dependent is an employee's spouse, unmarried children or spouse's unmarried children. This includes newborns, legally adopted children, unmarried children who qualify as eligible dependents as defined in the certificate, unmarried stepchildren or children for whom the employee or the employee's spouse is the legal guardian. It also includes children who are covered under Qualified Medical Child Support Orders (QMCSO).

Eligible employee/member

To be eligible to enroll, an individual must:

- Be an employee of the group who is entitled to participate in the benefit plan arranged by the group.
- Have satisfied any waiting or probationary period established by the group and meet the eligibility criteria in the group's contract.
- Be an employee of the group who is entitled to coverage under a trust agreement or employment contract.

Employee Retirement Income Security Act (ERISA)

A federal law that regulates certain pension plans and employee welfare benefit plans (including certain group health plans).

Explanation of Benefits (EOB)

After the member or the member's provider submits a claim, Anthem sends the member an EOB that shows the claims payment information. This includes the amount paid to the provider and any amount the member may owe. If a deductible or coinsurance applies, the amount applied to the member's deductible and out-of-pocket maximum will also be shown.

Health Insurance Portability and Accountability Act (HIPAA)

Federal legislation passed in 1996 that has multiple requirements, including insurance portability, privacy, security and electronic data requirements.

CarelonRx

This is the company providing pharmacy benefit management services for Anthem Blue Cross and Blue Shield effective January 1, 2020 for small group employers.

Limiting age

This is the age where a member's dependent child is no longer covered under the member's contract with the group.

Net eligible employees

The number of employees eligible for health insurance who don't have other group medical insurance (such as through a spouse).

Placement date

This is the date the member assumes and retains the legal obligation for total or partial support of a child in anticipation of adopting the child. The coverage is effective when the adoption is final.

Primary care physician (PCP)

A PCP is a family practitioner, general practitioner, internist or pediatrician who provides care and coordinates the member's medical treatment. Network PCPs meet qualification standards and are subject to periodic review.

Qualified Medical Child Support Order (QMCSO)

This is a Medical Child Support Order that's determined by the group to be "qualified," which then requires enrollment of the dependent.

Waiting period

A period of time as defined by the group's contract that your employee must meet before becoming eligible for coverage.

Together, we make a real difference!

We want to thank you, again, for trusting us with the health of your employees. We know that offering health coverage is a big and very important decision for your business. This valuable coverage is one we're committed to in every way – from helping your employees get and stay healthy to helping you, and them, save as much as possible through lower cost plan and care options. If you ever have any questions, please feel free to call us at 1-800-922-4770.

Our purpose is to transform health care with trusted and caring solutions. And it's great that we can do this together!

Anthem

Anthem Blue Cross and Blue Shield
Small Group Services
P.O. Box 172405
Denver, CO 80217-2405

anthem.com