California

Anthem

Group administrator manual

Small Group employers (1-100)

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

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Thank you for choosing Anthem

Welcome to Anthem. We've created this *Group Administrator Manual* to help you find quick answers about enrollment, billing, membership changes and other day-to-day administrative tasks. We're also available to speak with you one-on-one to answer your questions and help make your day easier! You can always get more help by logging in at **anthem.com/ca** or calling your Anthem Service team at 1-833-747-1190

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

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

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

We want to make sure that you have access to programs, tools and resources that can help you get the information you need, when you need it. Our 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/ca:

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

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How to get help

Important contact information

Questions about...	Contact	Phone/Fax/Email/Web	Address/Hours of operation (M-F, unless stated otherwise)
Billing	Billing team	Phone: 1-833-747-1190 Email: small.group@anthem.com Web: EmployerAccess	For premium payments: Anthem Blue Cross P.O. Box 51011 Los Angeles, CA 90051-5311 Hours: 8 a.m. - 5 p.m. PT
Enrollment	Enrollment team	Phone: 1-833-747-1190 Email: small.group@anthem.com Web: EmployerAccess	For correspondence: Anthem Blue Cross Small Group Services P.O. Box 9062 Oxnard, CA 93031-9062 Hours: 8 a.m. - 5 p.m. PT
Cal-COBRA and/or COBRA	Enrollment and Billing	Phone: 1-833-747-1190 Email: small.group@anthem.com Web: EmployerAccess(for COBRA only)	Anthem Blue Cross Attention: Cal COBRA Coverage P.O. Box 9062 Oxnard, CA 93031 Hours: 8 a.m. - 5 p.m. PT
Medical claims	Member Services	Phone: 1-855-383-7248	Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007 Hours: 7 a.m. - 7 p.m. PT
Health Savings Accounts, HSAs, or Spending Accounts	Member Services or Sales Support	Phone: 1-855-383-7248 (member) Phone: 1-833-747-1190 (employer) Email: SpendingAccountSupport@Anthem.com	
Pharmacy (general)	CarelonRx	Phone: 833-203-1742	Hours: 24 hours a day, seven days a week
Dental claims	Anthem Dental Prime and Complete Customer Service Dental Prime and Complete Dental Essential Choice	Phone: 1-877-567-1804 Phone: 877-604-2156 Phone: 844-729-1565	Anthem Dental Claims P.O. Box 1115 Minneapolis, MN 55440-1115 Hours: 5 a.m. – 5 p.m. PT
Vision claims	Blue View Vision℠ Customer Service	Phone: 1-866-723-0515	Blue View Vision Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111 Hours: Mon. - Sat., 7:30 a.m. - 11 p.m. PT Sun., 11 a.m. - 8 p.m. PT
Coverage while traveling (out-of-state providers)	BlueCard program	Phone: 1-800-810-2583 Web: bcbs.com	Hours: 24 hours a day, seven days a week
Section 125 Premium Only Plan (POP)	HealthEquity	Phone: 1-800-876-7548 Web: ezpop.com	Hours: 8 a.m. - 5 p.m. CT
Groups requesting reinstatements	Accounts receivable	Phone: 1-888-686-9807	Hours: 8 a.m. - 4:30 p.m. PT
Forms and supplies		Web: anthem.com/ca/forms or contact your broker or Anthem Service Representative	
EmployerAccess	Technical support	Phone: 866-755-2680 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
- Use the Find Care tool to help employees locate a doctor, hospital or other health care provider

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
- 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
- View and download your company's renewal package

Want to learn more about **EmployerAccess**? Give us a call at 1-800-922-4770 and find out how it can help you make managing your account easier and faster. Or take a look at our **EmployerAccess tutorials to managing your health benefits online**.

Submitting electronic eligibility transactions with Anthem

You can submit electronic enrollment using EmployerAccess, the Online Census Enrollment tool, 834 Electronic Eligibility Transfer file (EET), and Real Time. Anthem encourages the use of online enrollment for vendors, brokers, and general agencies to process and submit employee benefit elections and maintenance information.

Benefits of electronic enrollment:

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

Sending eligibility electronically can be used for both initial enrollment and ongoing maintenance. For an initial enrollment, a complete roster of employees with their dependents and their selected coverage may be required. If you're interested in starting electronic enrollment, contact your agent and/or Enrollment and Billing. See *Electronic enrollment and eligibility data submission guidelines for more information. E-submit* is Anthem's service that allows you to upload documents directly into our systems. You may upload one or as many documents as you like at one time – saving you time and effort.

Requesting access

The invitation ID needed to request an account is **Inv$t3** and the business unit is **WEST SMALL GROUP ACA**. After you click the Request Account button, an email will be sent to activate your account.

Materials and other documents

Please contact your broker or Anthem Services team to request forms, including applications, plan change and any other material needed. You can also access forms at anthem.com/ca/forms.

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 1-833-747-1190. You'll be prompted to say or enter your information. Then, simply press 1 to get options.

Welcome to Anthem Blue Cross Small Group Services department

Prompt	Response
Are you a... ○ Group administrator? ○ Broker? ○ Sales agent? ○ Member?	Say 'Group administrator'
Are you calling... ○ Billing? ○ Making a payment by phone? ○ EmployerAccess or something else?	

Understanding your group(s)

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

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

Summary of Benefits and Coverage (SBC)/Summary of Dental Benefits and Coverage (SDBC)

The Affordable Care Act (ACA) requires that all members of fully insured medical plans receive an SBC. Senate Bill 1008 requires all members of standalone dental plans receive an SDBC. Groups are responsible for sending an electronic or printed copy of the SBC/SDBC (if applicable) to participants and beneficiaries. SBCs/ SDBC's can be accessed at sbc.anthem.com.

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 and Cal-COBRA notices
- Medicare eligibility and individuals turning age 65
- Employer/Employee contribution
- Email address
- Employer tax ID number
- Form 5500 plan number (if applicable)

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

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

Determining group size

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

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

1 Health and Safety code 1357.500

Who is an employee?

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

The following do not qualify as an employee for purposes of group eligibility:

- An individual that wholly owns the company on their own or with their spouse/domestic partner;
- The spouses of a sole proprietors;
- Partner in a partnership and their spouses;
- A two-percent S corporation shareholder;
- A worker described in section 3508 of Title 26, Internal Revenue Service Code; or
- A leased employee (as defined in 26 U.S.C . § 414(n)(2))

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

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

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

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

Additional information

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

2 26 C.F.R. § 31.3401(c)-1(b).

The information in this document is intended only as general guidance to assist you in determining your group's size. It isn't intended as legal or financial advice or opinion. People seeking specific guidance concerning the ACA, the Internal Revenue Code or California State laws or regulations should consult with their attorneys, certified public accountants or other authorized consultants or advisors. These contents shouldn't be construed as or relied upon for legal or tax advice in any particular circumstance or factual situation.

Aggregation rules

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

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

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

Employee participation requirements

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

To calculate employee participation:

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

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

- Employees with Medicare, Medi-Cal or military coverage.
- Employees covered under another employer sponsored group plan, such as spouse/domestic partner, parent, etc.
- Those who have their own individual coverage either on or off the exchange.

The result indicates the total number of eligible employees.

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

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

Example 1 – Group meeting participation:

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

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

Example 2 – Group NOT meeting participation:

Total number of employees:	10
Invalid waivers (4 don't want coverage):	-4
Total number of eligible enrolled employees:	6

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

Product participation requirements

Medical participation requirements for 1-100

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

Examples of groups that aren't considered small employers:

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

Group participation requirements:

- 60% participation for groups with 1-14 eligible employees.
- 50% participation for groups with 15 or more eligible employees.
- The minimum participation is 100%, if noncontributory.
- For PPO plans with orthodontia, a minimum of 5 employees must enroll.

Anthem may conduct periodic audits to confirm participation levels. In the event of an audit, Anthem will require waiver forms and proof of current medical coverage for all eligible employees not currently enrolled.

The group must maintain the corresponding minimum participation levels in order to remain eligible. Groups are subject to cancellation or non-renewal if participation falls below the required minimum.

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

Dental participation for 2-100

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

Dental Net DHMO plan participation:

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

Group participation requirements:

- Participation: 2–100 eligible employees — 25% of eligible employees (a minimum of 2 employees must enroll).
- Dual option offerings are available to small groups with at least 5 net eligible employees, but the plans must have at least a 10% differential in premium rates. The 10% differential is based on the single rate for each quoted plan.
- Dual option is not allowed between 2 DHMO plans. Dual option must be between an Anthem PPO and Anthem DHMO plan (a dental Enrollment Verification Form must be provided with backup).
- Dual option participation guidelines require a minimum of at least 2 enrolled in each option. The group must also meet the minimum participation percentage stated in the Participation sections above.
- Orthodontic coverage for adults and children is included in all Dental Net DHMO plans.
- Waiting periods are not required for Dental Net DHMO plans (including plans with optional dental implant coverage).

Note: Dental Net DHMO office numbers are required.

Dental PPO plan enrollment requirements:

- Participation: 2–100 eligible employees — 25% of eligible employees (a minimum of 2 employees must enroll).
- Dual Option PPO plans (an employer can select 2 plans to offer to employees) are available for employer-sponsored plans. A dual option is available if the group has at least 5 net eligible employees. A minimum of 2 employees must enroll in each option, and the 2 plans offered must have at least a 10% premium differential.

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

- A minimum of 5 employees must enroll (there is no participation-percentage requirement for our voluntary plans).
- Dual Option (employer can select two plans to offer to employees) is available; a minimum of 5 employees must enroll in each plan. (You may choose one voluntary Dental Net DHMO plan and one voluntary Dental PPO plan. There must be a 10% differential in the premiums rates based on the single plan.)

Vision participation for 2-100

Employer-sponsored:

- Minimum participation is 100%, if noncontributory
- Dual Option (employer can select two plans to offer to employees) is available. (You may choose a maximum of two plans, but you may not pair a voluntary plan with an employer-sponsored plan.)

Voluntary vision:

- Voluntary vision plans available for 5–100 employee small groups. Must have a minimum of 5 subscribers enroll.
- Dual Option is available (employer can select two plans to offer to employees). You may choose a maximum of two employees, but you may not pair a voluntary plan with an employer-sponsored plan. Dual option requires at least 10 eligible employees. Five or more employees must enroll in each option.
- Voluntary vision is available as a stand-alone product or in conjunction with medical and/or dental.

Employer contribution requirements

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

Per the Consolidated Appropriations Act (CAA), please notify Anthem of any employer and employee's monthly premium contribution changes.

You have the following contribution options:

Medical

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

During the annual open enrollment period, November 15 to December 15, medical contribution/participation requirements won't be enforced.

Federal Employer Tax ID Number

Please notify Anthem if you Federal Employer Tax ID number has changed. Anthem is required for the notification of forms 1095-B and 1094-B to be filed electronically with the IRS for all fully insured plans. A 1095-B and 1094-B will generate to the Federal Employer Tax ID number we have on file. If we do not have a number on file a form will not generate.

Employer orientation and/or waiting periods

Pursuant to SB 1034 (2014), Anthem will not impose a waiting period. Groups are responsible for providing Anthem with accurate member eligibility dates, taking into account any group-imposed orientation and/or waiting period. An employer may impose bona fide employment-based orientation (affiliation) period for new employees which cannot exceed 30 days. If the employer imposes an orientation period when completing the application the "date of hire" is the first day after completion of the orientation period. A waiting period may also be imposed before coverage becomes effective, beginning the first day after any orientation period however, cannot exceed 90 days.

In accordance with SB 1034, groups are responsible for ensuring that any group-imposed waiting period is consistent with Section 2708 of the Federal Public Health Service Act(42 U.S.C. § 300gg-7).

The following are the waiting period options:

- If hired on the first of the month, the group can request to enroll on Date of hire Example: hired on 2/1/2025; eligible 2/1/2025
- First of the month following date of hire
- First of the month following one month from date of hire
- First of the month following two months from the date of hire, not to exceed 90 days
  - If it exceeds 90 days, the effective date will be first of the month following one month from the date of hire. For example, an new employee hired on March 2 would receive an effective date of May 1 because the first of the month that follows the second month (June 1) would total 91 days.

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

You may only choose one waiting period for your employees; ***dual orientation and/or waiting periods aren't allowed.***

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

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 an anniversary change has been approved within the lifetime of a group.

The anniversary date cannot be changed unless mutually agreed upon. The following actions and changes can only occur on your anniversary date:

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

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

Changes in ownership

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

Canceling group coverage

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

Examples of effective dates for groups requesting to cancel

	Example 1 of group cancellation	Example 2 of group cancellation
Request to cancel	April 1, 2023	April 1, 2023
Request received	April 25, 2023	May 6, 2023
Effective date	April 1, 2023	May 1, 2023

Termination of group coverage

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

- Failure to provide accurate eligibility information or other breach of contract
- Material misrepresentation
- Nonpayment of premium
- Failure to meet minimum contribution and/or participation requirements
- Employer submits a request to cancel the last enrolled active employee

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

Benefit modifications

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

Important note: Your group benefit agreement 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.

Subscriber changes

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

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

Benefit modification job aid

Benefit modification	When eligible	Documents necessary
Add or downgrade a medical plan	At a group's anniversary date	1. Letter/email from the group signed by owner/officer or renewal documents, if available 2. *Employee Enrollment Application*s for any new enrollments who aren't currently enrolled, or renewal documents, if available
Employer sponsored & Voluntary plans - Dental (Rates are based on eligible employee count)	First of the month following receipt of all documentation	1. Specialty Benefit modification form (SIC Code is required) 2. Copy of the Agent Quote 3. *Employee Enrollment Application*s for any new enrollments who aren't currently enrolled, or renewal documents, if available 4. Provider office number (for DHMO plans only) 5. Dental Net (DHMO) office numbers 6. Waivers for declining employees (not needed for Voluntary plans)
Employer sponsored & Voluntary plans - Vision Dual option requires at least 10 net eligible employees. In addition, 2 or more employees must enroll in each option. You may not pair a Voluntary Vision plan with an Employer Sponsored Vision Plan.	First of the month following receipt of all documentation	1. *Specialty Benefit Modification Form* 2. Copy of Agent Quote 3. *Employee Enrollment Application*s for any new enrollments who aren't currently enrolled, or renewal documents, if available 4. Waivers for declining employees 5. Rates based on the eligible employee count
Add part-time employee eligibility	First of the month following receipt of all signed documentation	1. Letter/email from the group signed by owner/officer 2. *Employee Enrollment Application(s)*, requesting or declining coverage for all eligible part-time employees 3. Current *Quarterly State Tax Withholding Report* reconciled 4. *Attestation* form **Note**: Additional documentation and review may be required.
Change contribution option Per the Consolidated Appropriations Act (CAA), please notify Anthem of any employer and employee's monthly premium contribution changes.	Once in a 12-month period, effective first of the month following receipt of documentation	1. Letter/email from group's owner/officer requesting the change

Benefit modification	When eligible	Documents necessary
Group demographic changes Name change with same owner and no new enrollments. First of the month following receipt of all documentation.	First of the month following receipt of all documentation	1. Letter or email from group signed by owner or officer requesting the name change 2. Fictitious Business Name Filing (sole proprietorship or partnership), or amended Articles of Incorporation (corporations), or amended Articles of Organization (Limited Liability Corp [LLC]) **Note**: Additional documentation and review may be required.
Name change with Federal Employer Tax ID number, same owner, and no new enrollments. Please note, the Federal Employer Tax ID Number is needed for the generation of the 1095-B and 1094-B.	First of the month following receipt of all documentation	1. Letter or email from group signed by owner or officer requesting the name change 2. Fictitious Business Name Filing (sole proprietorship or partnership), or amended Articles of Incorporation (corporations), or amended Articles of Organization (Limited Liability Corp [LLC]) 3. New *Employer Application* **Note**: Additional documentation and review may be required.
Name change with a Federal Employer Tax ID Number with new ownership and enrollment changes. Please note, the Federal Employer Tax ID Number is needed for the generation of the 1095-B and 1094-B.	First of the month following receipt of all documentation	1. Letter/email from group signed by owner/officer requesting the name change 2. New *Employer Application* 3. *Employee Enrollment Applications* for new owners with the Eligibility Statement completed in full 4. Purchase Agreement, Federal Tax ID Letter, Fictitious Business Name Filing (sole proprietorship or partnership), or Amended Articles of Incorporation (corporations)/ Organization (Limited Liability Corp [LLC]) **Note**: Additional documentation and review may be required.
Ownership change Name and Federal Employer Tax ID number remain the same.	First of the month following receipt of all documentation	1. Letter/email from group signed by owner/officer requesting the ownership change 2. New *Employer Application* 3. *Employee Enrollment Applications* for new owners with the Eligibility Statement completed in full (if owner is eligible) 4. Purchase Agreement or Amended Articles of Incorporation (corporations)/Organization (Limited Liability Corp [LLC]) **Note**: Additional documentation and review may be required.
Splits If the company maintains or inherits the same employees (covered prior to the split) Please note, the Federal Employer Tax ID Number is needed for the generation of the 1095-B and 1094-B.	First of the month following receipt of all documentation	1. Letter/email from group signed by owner/officer requesting the name change 2. New *Employer Application* 3. *Employee Enrollment Applications* for those enrolling in the new entity, as well as the termination request(s) from the prior group 4. Federal Tax ID Letter, Fictitious Business Name Filing (sole proprietorship or partnership), or Articles of Incorporation (corporations)/Organization (Limited Liability Corp [LLC]) 5. The most recent *Quarterly Wage and Withholding Report* for the original company indicating the status of each employee and who is going where 6. Eligibility Statement for owners not listed on *Quarterly Wage and Withholding Report* 7. Copy of agent quote 8. Initial payment **Note**: Additional documentation and review may be required.

Benefit modification	When eligible	Documents necessary
Mergers If a company insured with Anthem is merging with another company also insured by Anthem Please note, the Federal Employer Tax ID Number is needed for the generation of the 1095-B and 1094-B.	First of the month following receipt of all documentation	1. Letter/email from owner/officer of surviving group explaining and requesting the change 2. New *Employer Application* 3. Legal documentation of the merger 4. The most recent *Quarterly Wage and Withholding Report* from each *company, with the status of each employee* 5. *Employee Enrollment Applications* for all new employees enrolling or waiving coverage 6. Eligibility Statement for owners not listed on *Quarterly Wage and Withholding Report* along with documentation of ownership **Note**: Additional documentation and review may be required.
Acquisition If a company insured with Anthem is acquiring another company **not** insured with Anthem Please note, the Federal Employer Tax ID Number is needed for the generation of the 1095-B and 1094-B.	First of the month following receipt of all documentation	1. Letter/email from group signed by owner/officer explaining and requesting the change 2. Legal documentation of the acquisition 3. The most recent *Quarterly Wage and Withholding Report*, with the status of each employee 4. New *Employer Application* 5. *Employee Enrollment Applications* for all new employees enrolling or waiving coverage **Note**: Additional documentation and review may be required.

Member eligibility rules and requirements

Eligible employees

To be eligible for coverage, an employee must be in one of the following enrollment classes:

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

Employees living outside of **California**

Employees who live outside California are only eligible to enroll in PPO plans in the Prudent Buyer network and Select PPO network. **The majority of all eligible employees must be employed in California**.

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

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

Eligible dependents

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

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

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

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

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

What is a "domestic partner"?

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

- Domestic partners are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring.
- A domestic partnership shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State pursuant to this division, and, at the time of filing, all of the following requirements are met:
  - Neither person is married to someone else or is a member of another domestic partnership with someone else that hasn't been terminated, dissolved, or adjudged a nullity.
  - The two people aren't related by blood in a way that would prevent them from being married to each other in this state.
  - Both people are at least 18 years of age.
  - Both people are capable of consenting to the domestic partnership.

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

Children's age/qualification criteria

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

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

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

Over-age dependents

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

Coverage for over-age dependent children may be extended beyond the child's 26th birthday if certain conditions are met and the parent provides the required documentation to Anthem. When a dependent child's coverage terminates because the child has reached the limiting age, we will notify the subscriber at least 90 days before the child has reached that age. The subscriber must then submit a request for continued coverage for the child, along with proof of the applicable criteria described below, within 60 days of receiving our notification. Once we receive the subscriber's request and proof of the applicable criteria, we will determine whether the child is eligible for continued coverage before the child reaches the limiting age.

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 certain impairment or injury, and who is at least one-half dependent upon the subscriber for support and maintenance: Complete the *Request to Continue Dependent Coverage*. A doctor must certify the dependent's physically or mentally impairment 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 diagnosis/prognosis still exists.

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

To replace previous coverage with Anthem coverage: When a newly eligible employee has a dependent child over the age of 26, we will 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 indicated in your group's application. Monthly premiums will continue to accrue during an employee's short-term personal leave of absence, and you must continue to pay the required monthly premiums. However, you can request that the employee pay the premiums directly to you during this period.

You are not required to continue coverage for longer than the period indicated in your group's application. After the time period for continued coverage ends, an enrollee can elect to continue coverage under COBRA or Cal-COBRA, as applicable.

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

Short-term medical leave of absence

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

You aren't required to continue coverage 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're responsible for notifying us about an employee's short-term medical leave of absence begin and end dates.

Enrollment guidelines

Enrolling new employees

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

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

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

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

Remember, the fastest way to enroll a new employee (and dependents, if applicable) is online through EmployerAccess. See Online enrollment in the *Self-service options* section. If you aren't already registered for EmployerAccess, please call us at 1-833-747-1190 for details.

Completing eligibility dates on the application

Date of hire (MM/DD/YYYY) / /	Date of full-time employment (MM/DD/YYYY) / /	Date waiting period begins (MM/DD/YYYY) / /	No. of hours worked per week

- *Date of hire* – enter the date when a full-time or eligible part-time employees begins their duties as a new hire.
- *Date of full-time employment* – provide this information when a part-time employee has been offered full-time status
- *Date waiting period begins* – enter the date after the group-imposed orientation period has ended, the orientation period can be no greater than 30 calendar days from the employee's date of hire or date of full-time employment.

Enrolling eligible dependents

Type of dependent	Application for coverage or declining coverage must be received:	Must include (if requesting coverage):
New spouse or new domestic partner Coverage will begin on the event date following our receipt of documentation: • New spouse: *Employee Enrollment Application* • Same-sex new domestic partner: *Employee Enrollment Application* • Opposite-sex new domestic partner: *Employee Enrollment Application*	Within 60 calendar days of new marriage or new domestic partner registration	*Employee Enrollment Application*

Type of dependent	Application for coverage or declining coverage must be received:	Must include (if requesting coverage):
Newborn child The child will be covered for the first 31 calendar days from the date of birth. Coverage will continue beyond the 31calendar days, provided that the employee submits an *Employee Enrollment Application* to the group within 60 calendar days from the date of birth to add the child to the plan. If the employee submits an *Employee Enrollment Application* to the group within 60 days from the date of birth, coverage for the child under the plan will be effective beginning on the date of birth.	Within 60 calendar days of birth	*Employee Enrollment Application*
Adopted child In the case of adoption, or placement for adoption, the child will be covered for the first 31 calendar days from the date of adoption, or placement for adoption. Coverage will continue beyond the 31 days, provided that the employee submits an *Employee Enrollment Application* to the group within 60 calendar days from the date of adoption or placement for adoption to add the child to the plan. If the subscriber submits an *Employee Enrollment Application* to the group within 60 calendar days from the date of adoption or placement for adoption, coverage for the child under the plan will be effective beginning on the date of adoption or placement for adoption. A child will be considered adopted from the earlier of: 1. the moment of placement in the subscriber's home; or 2. the date of an entry of an order granting custody of the child to the subscriber. The child will continue to be considered adopted unless the child is removed from the home prior to issuance of a legal decree of adoption.	Within 60 calendar days of adoption or placement for adoption	*Employee Enrollment 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 60 calendar days of marriage or domestic partner registration	*Employee Enrollment Application*
Ward of a permanent legal guardian An unmarried child (ward) of a subscriber or the subscriber's enrolled spouse/domestic partner who is named the **permanent** legal guardian by a final court decree or order will be considered an eligible dependent child, subject to all rules and age limitations that apply to an eligible dependent child.	Within 60 calendar days of issuance of the final court decree or order of legal guardianship (or, if specified, within the time frame indicated in such court decree or order)	*Employee Enrollment Application* *Letter of Guardianship* form from the court, showing the filing date and court seal
Assumed parent-child relationship Child for whom the eligible employee has assumed a parent-child relationship (doesn't include foster children), as indicated by intentional assumption of parental status or assumption of parental duties by the eligible employee[1]	Within 60 days of qualifying event	Certification

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

Enrolling rehired employees

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

If the employee is rehired **more than** 31 calendar days from termination but not more than 91 calendar days, coverage shall restart effective on the rehire date. The rehired employee won't be subject to any applicable orientation and/or waiting period and must complete a new *Employee Enrollment Application*.

If the employee is rehired **more than** 91 calendar days (13 weeks) after the termination date, the employee is considered a new employee, subject to any applicable orientation and/or waiting period and must complete a

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

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

Effective dates are determined as follows:

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

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

Examples of effective dates for eligible employees

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

	Example 1 Employee submits application within the timeframe	Example 2 Employee submits application after eligibility date (within 45 days)	Example 3 Employee submits application more than 45 days after eligibility date	Example 4 Employee submits application, the group's waiting period is first of the month after hire date
Hire date	April 10, 2025	April 10, 2025	April 10, 2025	April 1, 2025
Eligibility date	June 1, 2025	June 1, 2025	June 1, 2025	May 1, 2025
Completed application received	June 15, 2025	July 1, 2025	August 1, 2025	April 15, 2025
Effective date	June 1, 2025	June 1, 2025	Group's next anniversary or approved qualifying event	May 1, 2025

Waivers

New employees who don't elect coverage or existing employees who choose to end coverage under your Anthem Small Group plan and/or policy must complete sections A and F of the Employee Enrollment Application or submit the *Employee Waiver Form*. We must receive the application after the hire date and before the last day of the month following the end of your group's orientation and/or waiting period. You're responsible for ensuring

that we receive applications from employees who are waiving coverage within the same time frame as applications from employees who are requesting coverage. (See *Enrolling new employees*.) Depending on why an employee chooses to waive coverage, they may be eligible to reapply at a later date with a valid qualifying event.

Open enrollment

After initial enrollment, employees can make changes to benefit elections at open enrollment. During open enrollment, a group can submit an application 30 days prior to its anniversary date and up to 31 days after. For example, if a group's anniversary date is April 1, 2025, it can be submitted between March 1, 2025, through April 30, 2025.

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

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

Special enrollment (for qualifying events)

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

- Open enrollment
- Marriage or Declaration of Domestic Partnership
- Birth or adoption of a child
- Involuntary loss of coverage
- Death
- Divorce or legal separation

HMO service area

Enrollment in the HMO Networks is dependent upon the employee residing or working within a plan's geographic service area, and the network, provider, and physician availability within the geographical service area. If at the time of enrollment the network or physician/medical group is not available or an employee does not reside or work in the geographical service area of the plan the employee may be assigned to or be required to choose a different provider, network, and/or plan.

Late enrollees

If we receive a new *Employee Enrollment Application* more than 45 days after the applicant becomes eligible, the subscriber and eligible dependents will be considered late enrollees and will have to wait until the group's anniversary date for coverage. This time period is known as open enrollment. See *Open enrollment* earlier in this section.

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

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

By fax: 1-855-750-2227

Enrollment actions guide

Electronic enrollment options:

- *EmployerAccess* – Online tool for brokers or groups to perform enrollment changes. This website helps you save time, reduce errors and get quick, convenient access to enrollment information. When it comes to making your life easier, we've got you covered. Handle your enrollment in real time, 24/7. It's the fastest way to enroll members and make changes, so your employees can start using their benefits as soon as possible. What's so great about online enrollments besides eliminating paper?
  - Fast and convenient: View or manage in real time – enrollments, changes and terminations
  - It's secure.
- *Online Census Enrollment (OCE)* – With OCE you can manage the enrollment process within a spreadsheet. Just enter all of the employees' and their dependent information into a pre-configured census template. Once it's uploaded to EmployerAccess, you'll have instant access to validate the enrollment details. It's one of the fastest ways to submit enrollments, so subscribers can start using their benefits as soon as possible.
- *Simple Census* – Offline Census Enrollment tool for brokers or groups to email large volumes of enrollment changes via an Excel spread sheet. The Simple Census tool is processed directly to our system as a self-service enrollment tool that makes it easier for group administrators to manage their open enrollment. You'll receive an Excel file that lets you enroll employees and dependents quickly and easily. When you're finished, just email it back to us.
- *Electronic File (834/1000 format)* – An Electronic Data Interchange (EDI) 834 file is the standard format in which employers can communicate their employees' health insurance enrollment and maintenance data to insurance carriers. This allows for scheduled batch processing of your enrollment records. For information on how to set up your 834 file, talk to your Anthem sales representative.

	How this action can be done							
	Electronic[1,2]				Paper			
	Employer Portal (Online tools)							
Action	EmployerAccess	Online Census Enrollment	Simple Census Enrollment	Electronic File (834/1000 format)	Employer Application	Employee Enrollment Application	Information Change Form	Employee Waiver
Add a **new** employee and/or dependents to the plan	✓	✓	✓	✓		✓		
Add dependents for an **existing** employee	✓		✓	✓		✓		

	How this action can be done							
	Electronic[1,2]				Paper			
	Employer Portal (Online tools)							
Action	EmployerAccess	Online Census Enrollment	Simple Census Enrollment	Electronic File (834/1000 format)	Employer Application	Employee Enrollment Application	Information Change Form	Employee Waiver
Waive coverage for an employee and their dependents	✓					✓		✓
Change plans for employees or dependents who already have coverage	✓		✓	✓		✓		
Terminate an employee and dependents from the plan	✓		✓	✓			✓	
Discontinue coverage for employees and/or dependents who still remain eligible under the plan	✓		✓	✓		✓	✓	✓
Change an employee's address	✓		✓	✓		✓	✓	
Notify us about a terminated employee and/or dependent that wish to continue COBRA or Cal-COBRA	✓		✓	✓			✓	
Remove a subscriber from federal COBRA	✓						✓	
Change the employer's address (This may affect the employee's rate.)	✓				✓		✓	

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

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

Electronic enrollment and eligibility data submission guidelines

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

When to send enrollment forms
See *Enrollment guidelines*.

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

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

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.

Plan changes

Covered subscribers may move to a different plan and/or product offered by the group at the ***anniversary month***. Plan changes may also occur with a qualifying event or special open enrollment. Electronic enrollment is Small Group's new standard for completing member level plan changes. This can also be done by completing the *Plan Change Request Form* on the anniversary date, submitting a written request or sending an email from the owner, officer or designated representative to small.group@anthem.com.

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

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

Part-time employees who have worked less than 12 months

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

Part-time employees who have worked more than 12 months

For employers that don't offer part-time coverage, part-time employees who become full-time employees are eligible to enroll as of the date they become full-time employees. Previous part-time employment isn't credited toward the orientation and/or waiting period unless the employee has worked continuously for at least one year.

You're responsible for informing us about the employment status of employees in a timely manner. When a full-time employee becomes a part-time employee and the group plan and/or policy doesn't extend coverage to part-time employees, the employee is no longer eligible for coverage as of the first day of the month following the employee's change to part-time status. Electronic submission is Small Group's new standard to delete employees from your plan. If you have opted out of electronic submission, please submit these changes on an *Information Change Form*. (See *Eligible employees* for definitions of full-time and part-time.) Once coverage ends, the employee may have the option to continue coverage under COBRA or Cal-COBRA benefits. (See *Continuation of coverage* for more information.)

Canceling employees from the plan

Electronic enrollment is Small Group's standard to delete employees from your plan. This can also be done by completing section 2 of the *Information Change Form*.

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

- Employment is terminated.
- An eligible full-time employee changes to a part-time employee, and your plan doesn't cover part-time employees.
- An employee is on a leave of absence (medical and/or personal) and the time period that the employer covers employees on leave has expired.
- An eligible part-time employee's work is permanently reduced to less than the minimum number of hours per week (20–29 hours per week).

- An eligible employee becomes ineligible by becoming seasonal, temporary, substitute or 1099.
- An employee otherwise becomes ineligible to participate in the plan.
- The employee no longer wants to continue federal COBRA coverage.

Please include the following information:

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

If you have opted out of electronic enrollment, you may send your termination notices to us:

By email: small.group@anthem.com

By fax: 1-855-750-2227

By mail: For correspondence:
Anthem Blue Cross
Small Group Services
P.O. Box 9062
Oxnard, CA 93031-9062

Please don't include the *Information Change Form* or any correspondence with your monthly payment.

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

Due to applicable state law, retroactive plan and/or policy terminations aren't allowed. When a member's employment is terminated, the employee must be canceled from the group. Employees who elect to continue coverage under COBRA must still be canceled from the plan. After Anthem is notified about the COBRA election, the member will be enrolled under your COBRA benefits.

You're obligated under law and by contract with Anthem to notify employees of their termination of coverage and of any rights to continue coverage. For Cal-COBRA eligible groups, notifications are sent by Anthem once you notify us of the employee's termination (See the *Cal-COBRA* section). Failure to do so exposes you 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 terminated employee will be reflected on a future billing.

Anthem does not accept retroactive terminations.

Employee termination dates

	Example 1	Example 2
Last day worked	April 3, 2025	April 3, 2025
Requested employee cancellation	May 1, 2025	May 1, 2025
Request to cancel received	April 1, 2025	June 15, 2025
Effective date of cancellation	May 1, 2025	June 1, 2025

- Employees who worked on the first of the month won't be taken off the plan and/or policy until the first of the following month.
- Cancellation dates are the first of the month only with the exception of the death of an employee with no enrolled dependents.

Canceling employees who remain eligible but discontinue coverage

Electronic enrollment is Small Group's new standard to delete employees from your plan. See the *Enrollment actions guide* for more information on electronic enrollment. If you opted out of electronic enrollment, you may complete the *California Employee Waiver Form for Small Groups*.

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

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 12 months) covers only totally disabling conditions. It is subject to review every three months. An extension of benefits must be requested in writing or by calling your Anthem Service team within 90 days of the cancellation of coverage. (See *Continuation of coverage* for more information.)

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.

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

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

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

About your billing

Premium rates

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

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

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

Premium payments

Paperless billing and online payment is the new standard for Anthem Small Groups.

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

Opting out of electronic bills

If you previously consented to receiving your plan materials electronically including bills, but now wish to receive your bill by mail, you may send an email to sgeapayments@anthem.com with "Opt Out" in the subject line. Provide your group number, contact name, email address, phone number and reason for opting out of electronic billing.

Notification when bill is ready

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

Options for making your payment

Pay online

Start paying your premiums online today. Electronic premium payments are faster and simpler than paper 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 1-833-747-1190.

You can choose one of these ePayment options:

1. **EasyPay**, it's a super-fast, free self-service option to submit a single premium payment. You simply make your payment as a GUEST user. All you need is your group's tax ID and your case or group number to get started. Visit easypay.anthem.com today.
2. **EmployerAccess** is a great way to pay your premiums online. Log in to EmployerAccess and set up your ePayments on the "*billing*" tab. It takes just a few minutes to pay your premium when you choose "*pay online now*." Plus, it's free and secure.

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 *Premium payments*.

Pay with check by mail

Mail your check and the coupon to:

For premium payments:
Anthem Blue Cross
P.O. Box 51011
Los Angeles, CA 90051-5311

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

- Always write your group number on the face of the check.
- Always send your coupon with the check. Please don't mail multiple checks in a single envelope.

Please note: This is a lockbox 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 call **1-833-747-1190** and pay by phone from your business checking account.

Please make sure to check that each monthly bill is accurate. Notify us immediately at 1-833-747-1190 if there are any discrepancies. It's important that the full amount of the premium listed on the bill is paid each month. Separate checks for each of the group's Anthem products aren't required.

Adjustments to your bill – employee/dependent additions and deletions

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

Please don't adjust your premium payment with credit for terminated employees. Pay your premium as billed. Payments not made "in full" will subject your account to termination. We strongly suggest that you submit terminations 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 terminations. See COBRA for the employer's responsibility on submitting COBRA premium payments.

Important note: Please don't submit termination(s) with your premium payment. Terminations won't be processed because they will go to the premium payment lockbox, not directly to Anthem. Instead, please email your termination request to small.group@anthem.com. 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. To submit member changes, refer to the *Enrollment actions guide*.

Administrative fees[1]

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

- **Reinstatement fee**

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

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

- **Returned check fee**

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

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

1 Administrative fees are subject to change.

Nonpayment of premiums

We reserve the right to end your Small Group plan and/or policy for nonpayment. If you don't remit your payment on time, your Small Group plan and/or policy will be canceled, effective on the first day after the grace period ends. You have a 30-day grace period to pay your premium.[1] Since you have coverage throughout the grace period, premiums are due for that period. 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. 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.[2]

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

1 Payments are due and payable in full upon receipt. Payments received after the first day of the month for which coverage is in effect are deemed "late" and penalties may apply.
2 Premiums must be paid in full by the end of the grace period (30 days) in order for coverage to continue. See your plan and/or policy for grace period details. Reinstatement is at the absolute and sole discretion of Anthem and reinstatement fees will apply. Please note: Depositing a check doesn't constitute acceptance of premium or a guarantee of coverage.

Continuation of coverage

When a member's employment with your company ends, he or she **must be canceled** as an active employee. If the past employee is eligible for COBRA or Cal-COBRA and later selects this option within guidelines described by law, we will re-enroll the member with COBRA or Cal-COBRA coverage with no lapse. Your group must be active. Member eligibility on COBRA or Cal-COBRA is dependent upon your group retaining active coverage.

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

You're responsible for notifying us in a timely manner about changes in group size that cause changes in your group's Medicare and COBRA status.

In order to ensure compliance with state and federal laws, we need you to update Anthem annually with your company's Cal-COBRA or COBRA and Medicare eligibility. Eligibility is determined by the number of employees in your group in the preceding calender year. Failure to supply updated information may result in incorrect payments for your employees' claims and may raise issues for your group under certain applicable federal laws.

Cal-COBRA

Under California law, Cal-COBRA provides continuation of coverage for groups that employ from 2 to 19 eligible employees for at least 50% of the working days in the previous calendar year. Groups of one employee aren't eligible for Cal-COBRA.

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

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

The employer must notify us within 31 days from the date that the qualifying event occurred. You may complete the termination on EmployerAccess or by completing Section 2 of the *Information Change Form*. The date and a description of the qualifying event must be included on the form.

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

We will bill the subscriber directly on a monthly basis for the premium. The subscriber is responsible for paying the premium in full each month. Premiums begin to accrue from the employee's coverage cancellation date under the group plan and/or policy. No lapse in coverage may occur. Premiums from the date of cancellation through the date of Cal-COBRA election are due. Failure to pay by the specified due date will result in termination of coverage with no option to reinstate. The employer won't be charged the Cal-COBRA premiums.

Cal-COBRA premiums include a 10% administrative fee.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Participation in the employer's benefit plan, as well as coverage under other health programs you provide to employees and their dependents, may be continued under a federal law known as COBRA for groups that employ 20 or more employees for at least 50% of the previous calendar year. Administration, for the purpose of compliance with COBRA, is your obligation under this federal law. Anthem isn't responsible for COBRA administration. (See *POP, FSA and COBRA administration* for information about COBRA administration services offered by HealthEquity.) You're responsible for providing satisfactory notice to employees about COBRA benefits, as well as disclosure and other administrative obligations imposed under the Employee Retirement Income Security Act (ERISA).

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

Under California law, members who are covered for 18 or 29 months under COBRA are eligible to extend their coverage under Cal-COBRA for up to a combined maximum of 36 months.

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

COBRA-eligible dependents

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

You'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. Please note that groups with under 20 employees are Cal-COBRA eligible. Groups with over 20 employees are federal COBRA eligible. If you use a third-party administrator (TPA) for your payroll/COBRA, you must still adhere to the above guidelines.

Cal-COBRA plans only

Anthem allows a one-time reinstatement exception of a non-pay termination. This exception requires administrative approval and is not bound to the delivery of an Anthem processing error.

Example:

Anthem receives a request to reinstate a Cal-Cobra policy. The request is routed to Small Group Enrollment department for review. Enrollment will complete a standard AB2470 review. If the determination is "deny request to reinstate", Enrollment will then review the request for eligibility under the one time reinstatement exception policy.

Notes:

- Enrollment will review current reinstatement policies prior to considering the one time reinstatement request.
- Enrollment will utilize the more lenient policy when reviewing the reinstatement request.

Contracts that cancel for nonpayment of the binder (initial) payment are not eligible for this policy.

Canceling COBRA members

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

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.

Medicare eligibility reason	Primary payer
Aged 65 or older and covered by a group health plan because of current employment of member or spouse • Employer has 20 or more employees • Employer has less than 20 employees	 Anthem Medicare
Under 65, Medicare incapacitated • Employer has 100 or more employees • Employer has less than 100 employees	 Anthem Medicare
End Stage Renal Disease ESRD any age, any size employer • First 30 months after Medicare eligibility • After 30 months	 Anthem Medicare

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.

In order to ensure compliance with state and federal laws, we need you to update Anthem annually with your company's Cal-COBRA or COBRA and Medicare eligibility. Eligibility is determined by the number of employees in your group in the preceding calender year. Failure to supply updated information may result in incorrect payments for your employees' claims and may raise issues for your group under certain applicable federal laws.

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 they have 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. You can find a list of Anthem plans which are "creditable" or "non-creditable" on anthem.com/ca/forms and in your yearly renewal. 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.

POP, FSA and COBRA administration

Section 125 premium only plan (POP)

Offered by HealthEquity, Inc.

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

Helping employees use their benefits

ID cards and Evidence of Coverage/certificates

ID cards

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

Combined Evidence of Coverage

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

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 or see *Important contact information* to find the address. Please refer to your *Certificates* and/or a *Combined Evidence of Coverage and Disclosure Form* (EOCs) for additional guidance/requirements on services and/or supplies.

WealthCare Administration (WCA) – HSA banking administrator

WCA is Anthem's Health Savings Account (HSA) Banking Administrator that delivers flexible plan options and gives you and your employees everything they need – the ability to drive cost savings, easy administration and robust support toward smart health care choices.

If you elect to offer an HSA plan and want the WCA integration, complete the *HSA Banking Questionnaire*.

Setting up accounts and enrolling employees

Step 1. Employee elects HSA compatible medical plan and enrollment data is submitted to Anthem.

Step 2. Anthem completes enrollments and transmits subscriber data to WCA.

Step 3. WCA initiates benefit accounts overnight.

- Employees' HSA accounts will go into "pend" status and they'll receive an email (if we have an email address on file) or a letter asking them to opt in.
- Employee completes opt in, The HSA account goes through a customer identification program (CIP).
- If the employee passes CIP the account is opened, the HSA account will move to active status.
- If the employee doesn't pass CIP If they don't, they'll receive instructions about what to do next.

Step 4. Welcome letters and debit cards are sent to the employees.

Step 5. Accounts are funded and ready for claims and debit card transactions.

Employees manage their HSA account online

When you sign up with WCA, employees can see and manage their benefits, find and compare providers and costs, manage claims payments and check account balances by logging into anthem.com/ca or the Anthem Sydney app.

Employees use their account dashboard to view a summary of their spending account, including current balance. They'll also see recent alerts and transactions, with dates and status information. Along the top left of the account dashboard page, they'll see four options: My Accounts, Claims, Resources and How It All Works. Each one has a drop-down list of tasks to choose from.

Encourage your employees to log into anthem.com/ca or the Sydney app to manage their spending account.

Paying for qualified medical expenses

Employees can pay for qualified medical costs with their plan debit card or request reimbursement for costs already paid.

Why use a plan debit card?

- It works like a standard debit card, but funds are spent from the employee's WCA HSA spending account.
- It provides real-time, on-demand access to funds.

Paying out of pocket

When there isn't an option to use a debit card, or an employee just prefers not to use one, they can pay for qualified medical expenses out of pocket and request to be reimbursed by:

- Submitting a claim through the Sydney app or anthem.com/ca.
- Sending in a claim form with proper documentation. The claim form can be found on the member website in the Resources section.
- Logging into their account online and reviewing medical, pharmacy, dental or vision claims and requesting reimbursement.

Need help?

Whether you or your employees have questions now or in the future, you can count on Anthem to help you whenever and wherever you need us.

For employers:
Phone: 1-833-747-1190
Email: SpendingAccountSupport@Anthem.com

For members:
If your employees have any questions about their medical plan or benefits accounts, they only need to call one number to speak with a representative. Our Member Services number is 1-855-383-7248 and appears on the back of their member ID card as well as their debit card.

They can call the same phone number to use these great self-service features as well:

- Activate their debit card
- Check account balances
- View recent transactions
- Create or change their PIN

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

- *Sydney* — Your employees can see a board-certified doctor or licensed therapist through live video on their smartphone, tablet or computer with a webcam. Sydney 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/ca* — 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/ca and select **Health & Wellness Center** under **Care**.

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

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

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

To locate a BlueCard PPO participating provider, members navigate to https://www.bcbs.com/find-a-doctor.

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

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:

- Go online — View and print forms from our website at anthem.com/ca/forms.
- Call your Anthem Service team at 1-833-747-1190 — Forms can be emailed or mailed to you.

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 domestic partner 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 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 1-833-747-1190.

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

Anthem

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Small Group Services
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CarelonRx, Inc. is an independent company providing pharmacy benefit management services on behalf of your health plan.

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