

Anthem

1–100 Small Group underwriting guidelines

45277CABENABC Rev. 10/25

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Useful links

Anthem website
anthem.com/ca

Broker Portal
Use this link to access Quoting Tool, Renewals, Producer Toolbox, Bills, and Broker News.
brokerportal.anthem.com/apps/ptb/login

Employer Access
Use this link for employer news, member maintenance, online bill pay, and online census enrollment.
employer.anthem.com/eea/public/login

BrokerHub
anthembrokerhub.com

Standard Industrial Classification (SIC) codes
osha.gov/data/sic-search

The Benefits Guide
thebenefitsguide.com

Summary of Benefits
plan-summaries.anthem.com/sobdps

Summary of Benefits and Coverage (SBC)/
Summary of Dental Benefits and Coverage (SDBC)
sbc.anthem.com

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Introduction to the underwriting process

This guide will provide you with clear guidance to help your clients choose the best healthcare options. At Anthem Blue Cross, our goal is to continuously improve the way small business provides health benefits to their employees, while being a strategic partner with our broker community. We want to help you grow your book of business, increase client retention, and create an easy-to-do-business-with environment.

Agents are not authorized to bind or guarantee issue coverage. Anthem will make the final decision to accept or decline a case. Please advise your prospective clients to maintain their current coverage until we notify them in writing that Anthem has approved their coverage. While Anthem is committed to keeping all parties informed of changes to the *Small Group Underwriting Guidelines* in a timely manner, Anthem may change the guidelines without prior notice.

Thank you for choosing Anthem.



General underwriting guidelines for Small Group

Group eligibility requirements

An employer that meets the eligibility requirements under the Affordable Care Act (ACA) and under the California Small Group regulations is eligible for guarantee issue and guaranteed renewal under a Small Group health plan.

- A Small Group employer is defined as employing an average of at least one, but no more than 100, full-time (including full-time-equivalent) employees. Most of these employees are employed within California on at least 50% of the employer's working days during the preceding calendar year or preceding calendar quarter. The employer has at least one employee on the first day of the plan year. For purposes of determining employer eligibility in the Small Group employer market, California adopted the federal method for counting full-time employees and full-time-equivalent employees (SB 125, 2015).
- An employer must be a person, firm, proprietary, or nonprofit corporation, partnership, public agency, or Guaranteed Association. The employer must be actively engaged in business or service.
- An employer must have and maintain business licensure and/or appropriate state filings, allowing the company to conduct business in California.
- The group must have its principal business address in California.
- An employer must not have been formed primarily for the purpose of obtaining health insurance.
- An employer must involve a bona fide employer-employee relationship.
- An individual who wholly owns the company or with their spouse or domestic partner, the spouses of sole proprietors, partners of a partnership and their spouses, a 2% S corporation shareholder, a worker described in Section 3508 of Title 26, Internal Revenue Code, or a leased employee, as defined in 26 U.S.C. § 414(n)(2), does not qualify as an employee for purposes of group eligibility.

Aggregation rules — All employers treated as a single employer under Section 414(b), (c), (m), or (o) of the Internal Revenue Service (IRS) 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 considered in determining whether the members of the controlled group or affiliated service group together are an applicable Large Group employer.

Affiliated companies — Under common control are required to enroll separately unless they are eligible to file a combined tax return for the purposes of state taxation. In determining group size, affiliated companies eligible to file a combined tax return for purposes of state taxation are considered one employer, even if they are not presently filing together.

Ineligible for group coverage:

- Owner-only group: on their own or with their spouse or domestic partner, officer, or partner.
- Carve-out groups.
- Employer groups with less than 51% of employees working in California.
- Seasonal, temporary, and substitute employees, defined as employees hired with a planned future termination date.
- Contract employees (1099) or employees compensated on a 1099 basis.
- Sole proprietors, spouses of sole proprietors, partners of a partnership, and the spouses of the partners.
- Employees who reside outside of the 48 contiguous states, Washington, D.C., Alaska, Puerto Rico, or the United States Virgin Islands.
- A group wanting to reapply for Anthem may be ineligible if they have not complied with prior requirements and/or have an outstanding premium balance.

Note: See "California underwriting business requirements" for sole proprietors, partners, or corporate officers not appearing on the *Quarterly State Tax Withholding Report* (DE 9C).

California underwriting business requirements

Sole proprietors

A sole proprietor employer must employ at least one common-law employee as anyone who performs services for an employer that has the right to control and direct what will be done and how it will be done, as defined by federal law and/or IRS guidelines.

Required document:

- Reconciled *Quarterly State Tax Withholding Report* or payroll report

Business and ownership documents — provide one of the following:

- Schedule C
- Current California business license
- Fictitious business name filing

If the owner is not on the quarterly wage report, please submit a completed *Anthem Eligibility Statement*.

Single owners and spouses or domestic partners of single owners don't constitute the qualifying W-2 employee.

Corporations — C corporation, S corporation

Corporations must provide the following:

- Reconciled *Quarterly State Tax Withholding Report* or payroll report

If officer(s) is not on the quarterly wage report, please also submit the following:

- *Anthem Eligibility Statement*

One of the legal documents below:

- Statement of Information (Articles of Incorporation with stamped meeting minutes listing the names of the officers may be considered.)
- For C corporations, Form 1120 with Schedule 1125-E
- For S corporations, Form 2553 signed by all officers

Corporations established out of state will also need to provide a *Certificate of Qualification* or *Statement by Foreign Corporation* in addition to the above documentation. If the percentage of ownership is zero, the enrolling corporate officer must appear on the reconciled *Quarterly State Tax Withholding Report*. Two-percent S corporation shareholders, owners, and spouses or domestic partners of officers or partners do not constitute common-law employees.

Nonprofit organizations and corporations

IRS Publication 557 has several types of 501(c) organizations, such as:

- 501(c)(3) — religious, educational, charitable, scientific, literary, testing for public safety.
- 501(c)(1) — corporations organized under Act of Congress (including federal credit unions).

Nonprofit companies must provide the following:

- Reconciled *Quarterly State Tax Withholding Report*, if available, or other objective indicia of employment
- *Anthem Eligibility Statement*
- California secretary of state active web confirmation
- IRS letter 501(c)(3)
- IRS application for exempt status

Members of the clergy who do not appear on the *Quarterly State Tax Withholding Report* should submit a Schedule SE or Form 4361 with IRS approval.

Partnerships — general and limited liability partnerships (LLPs)

A partnership employer must employ at least one common-law employee as anyone who performs services for an employer that has the right to control and direct what will be done and how it will be done, as defined by federal law.

Partnerships must provide all of the following:

- Current Schedule K–1 (Form 1065) (If this is not available due to the length of time in business or because there is an extension to file, a *Partnership Agreement* and federal tax ID appointment letter may be substituted.)
- *Anthem Eligibility Statement*
- Reconciled *Quarterly State Tax Withholding Report*, if available, or other objective indicia of employment

Limited liability partnerships registered out of state will also require a Registered Limited Liability Partnership Certificate of Registration filed and stamped with the California secretary of state.

Single owners and spouses or domestic partners of officers or partners do not constitute the qualifying W-2 employee.

California underwriting business requirements

Partnerships — limited partnerships (LPs)

Limited partnerships must provide all of the following:

- Current Schedule K–1 (Form 1065) (If this is not available due to the length of time in business or because there is an extension to file, a *Partnership Agreement* and federal tax ID appointment letter may be substituted.)
- *Anthem Eligibility Statement*
- Reconciled *Quarterly State Tax Withholding Report*, if available, or other objective indicia of employment

If limited or general partners are not listed showing wages on the reconciled *Quarterly State Tax Withholding Report*, the group will also need to provide a current Schedule K–1 (Form 1065). (If this is not available due to the length of time in business or because there is an extension to file, a *Partnership Agreement* and federal tax ID appointment letter may be substituted.)

Limited partnerships established out of state will also require a *Foreign Limited Partnership Application for Registration* (Form LP-5) filed and stamped by the California secretary of state.

Single owners and spouses or domestic partners of officers or partners do not constitute the qualifying W-2 employee.

Limited liability companies (LLCs)

Limited liability companies must provide the following:

- Reconciled *Quarterly State Tax Withholding Report*, if available, or other objective indicia of employment
- *Anthem Eligibility Statement* for all enrolling officers

If managing members are not listed showing wages on the reconciled *Quarterly State Tax Withholding Report*, the group will also need to provide a current Schedule K-1 (Form 1065).

Group will need to provide one of the following documents:

- Statement of Information or Articles of Organization with Operating Agreement

Limited liability companies established out of state will also need to provide a *Limited Liability Company Application of Registration* filed and stamped by the California secretary of state.

A single-member LLC or disregarded entity will be considered to have one owner.

Single owners and spouses or domestic partners of officers or partners do not constitute the qualifying W-2 employee.

Startup companies

A startup group can be considered for Small Group coverage. Anthem considers a startup group as an employer that has been in business and has employed at least one eligible common-law employee for less than a calendar quarter.

- Standard group eligibility requirements apply — refer to the group eligibility section.
- Complete and submit *Conditions of Enrollment/ Start-Up Companies/PEO Spin-Off Groups* form. Please include all available payroll records.
- Group must provide the first two weeks of payroll within 45 days of the effective date.

Single owners and spouses or domestic partners of officers or partners do not constitute the qualifying W-2 employee.

Professional employer organization (PEO) spinoff groups

Employees associated with a PEO are employed by the business listing the employees on its DE 9C. A business leasing employees from a PEO cannot cover employees under Anthem group coverage.

- Standard Group eligibility requirements apply — refer to the group eligibility section.
- Group must provide a copy of the PEO client invoice billed to the worksite business, which includes the names of each employee previously leased to the worksite employer.
- Group must sign a *Conditions of Enrollment/Start-Up Companies/PEO Spin-Off Groups* form.
- Employees will retain their original hire dates.
- A PEO Agreement must be terminated at the time of approval.

PEO subhybrid groups are eligible to enroll

Groups currently with a PEO that chose to remain in the PEO for various services must meet the following criteria:

- The PEO subgroup must qualify and enroll on a stand-alone basis, separate from the PEO.
- Employees of the PEO are not eligible to enroll in the subgroup.
- The principal business address of the subgroup must be in California and indicated on the employer application.
- General Agreements and Section K of the employer application must be signed by an authorized representative of the subgroup, not the PEO.
- COBRA provisions are determined by the subgroup's size only.
- A PEO subgroup letter or attestation must be included with the new group submission paperwork.
- A DE 9C or quarterly wage report is not required for groups of three or more enrolled through fourth-quarter 2024 effective dates.
- A copy of last month's Prior Carrier Bill is required for all products selected. The most-recent two weeks' payroll is required for enrolling employees not on the Prior Carrier Bill Excludes Virgin Groups.
- Groups without prior coverage will need to submit a DE 9C or quarterly wage report and/or payroll report.

Spinoff groups leaving a PEO employee leasing arrangement are subject to startup company underwriting guidelines:

- A PEO Agreement must be terminated at the time of approval.
- Employees will retain their original hire dates.
- Complete and submit a *Conditions of Enrollment/ Start-up Companies/PEO Spin-Off Groups* form.
- Standard group eligibility requirements apply — refer to the group eligibility section.
- The group must provide a copy of the PEO client invoice billed to the worksite business, which includes the names of each employee previously leased to the worksite employer.

Union versus nonunion

- Standard group eligibility requirements apply —refer to the group eligibility section.
- A copy of the union roster will be required from the employer identifying union members or the union collective bargaining agreement.
- Groups that exceed 100 employees (combined number of union and nonunion employees) may be considered for Large Group eligibility.
- A potential review of group fallout from nonunion may be used as a valid waiver.

Households

- Private households must have an employer identification number (EIN) and provide a quarterly wage report.
- Private household employers who pay annually will not be eligible.



General underwriting guidelines for Small Group business

Employee eligibility requirements

- Permanent full-time employees who conduct business of the Small Group employer, with a normal workweek of an average of 30 hours per week over the course of a month, at the Small Group employer's regular place of business, who have met statutorily authorized applicable orientation and/or waiting period requirements.
- Sole proprietors or partners of a partnership, if they are actively engaged an average of 30 hours per week over the course of a month on a permanent and full-time basis, or at least 20 hours but not more than 29 hours per week on a permanent basis for at least 50% of the weeks in the previous calendar quarter in the employer's Small Group business, and included as employees under a healthcare service plan contract of a Small Group employer.
- Permanent part-time employees who work at least 20 hours, but not more than 29 hours, are deemed to be eligible employees if all four of the following apply:
  - The employee otherwise meets 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 worked at least 20 hours per normal workweek for at least 50% of the weeks in the previous calendar quarter. The healthcare service plan may request the 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 must reside within the 48 contiguous states, Alaska, Puerto Rico, Washington, D.C., or the United States Virgin Islands.

Note: Owners may demonstrate that they meet the eligible employee criteria by providing W-2s or completing an *Anthem Eligibility Statement* form.

Dependent eligibility

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)
- Incapacitated dependent child, who at the time of becoming age 26, is incapable of self-sustaining employment by reason of a physically or mentally incapacitating injury, illness, or condition, and is chiefly dependent on the subscriber for support and maintenance. A dependent may be eligible for benefits beyond their 26th birthday. The employee will be required to submit physician certification of the child's condition.
- **Eligible child(ren) under age 26:**
  - Natural child
  - Stepchild
  - Legally adopted child
  - Ward of legal guardian
  - Child for whom the eligible employee has assumed a parent-child relationship (does not include foster children), as indicated by intentional assumption of parental status or assumption of parental duties by the eligible employee. The employee for the annuitant must certify at the time of enrollment of the child and annually thereafter.
  - In the case of birth, adoption, or placement for adoption, the child will be covered for the first 31 days from the date of birth, adoption, or placement for adoption. To continue the plan beyond the 31 days, Anthem must receive an application for coverage of a dependent child within 60 days of the child's eligibility. Coverage will be effective beginning on the date of birth or adoption or placement for adoption following our receipt of the completed *Employee Enrollment Application*.

- A child will be considered adopted from the earlier of the moment of placement in a group member's home, or the date of an entry of an order granting custody of the child to the group member. The child will continue to be considered adopted unless the child is removed from the member's 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.
- New spouses and/or domestic partners have 60 days from the date of marriage or affidavit of domestic partnership.

Enrolling rehired employees

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

If the employee is rehired more than 31 days from termination but not more than 91 days, coverage shall restart effective on the rehire date. The rehired employee will not be subject to applicable group-imposed orientation and/or waiting periods and must complete a new *Employee Enrollment Application*.

If the employee is rehired more than 91 days (13 weeks) after the termination date, the employee is considered a new employee, subject to applicable group-imposed orientation and/or waiting periods, and must complete a new *Employee Enrollment Application*.

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

Residents of Hawaii (medical only)

Anthem is neither a Hawaii-authorized insurer nor a Hawaii healthcare contractor. Our benefits may not match the requirements of the Prepaid Health Care Act. Please obtain direct quotes for either an individual policy for employees and/or dependents who live and work in Hawaii or, if there are several employees and/or dependents within an employer group, obtain group coverage from a Hawaii-authorized insurer. This would ensure that all the state requirements are met.

New group submission criteria

Anthem evaluates submissions on the following criteria:

- Headquartered in California
- Business or legal documentation
- Employee and dependent eligibility
- Employee participation
- Employer contribution

What to submit (employer level)

The following group-level documentation is required when submitting new business:

- A copy of the agent's final sold quote.
- The most current *Employer Enrollment Application/ Fillable Application*, including:
  - The Cal-COBRA/COBRA/Medical Leave questionnaire.
  - The last billing statement listing COBRA/ Cal-COBRA subscribers, if applicable.
  - A copy of the company's most recent reconciled *Quarterly State Tax Withholding Report* (DE 9C) with the current employment status of all employees listed (additional payroll documentation may be required).
    - First quarter due with the state by April 1
    - Second quarter due with the state by July 1
    - Third quarter due with the state by October 1
    - Fourth quarter due with the state by January 1
- If "takeover" coverage, a copy of the prior carrier's last month's group billing invoice with the status of all listed employees.
- A completed electronic funds transfer authorization form for 100% of the first month's premium (made payable to Anthem). If an electronic debit is not agreed to, a company check may be accepted, **subject to additional processing time**.
- Anthem is required by the IRS and Centers for Medicare & Medicaid Services (CMS) regulations to collect employer tax ID numbers, Form 5500 ID numbers (if applicable), and Social Security numbers.

Employee enrollment

- Each eligible employee or owner must complete an application or waiver.
- All eligible employees or dependents must have a valid Social Security number to enroll. If they do not have a valid Social Security number, they must complete a *Social Security Number Exception Form*.

Agents must keep a copy of the employee application or waiver.

Submission timeline

For new group submissions, make sure all required forms are completed accurately and included with your submissions.

- Anthem will accept new group submissions for the following effective dates:
  - First of the month — must be received by the fifth working day of the month.
  - 15th of the month — must be received by the 12th calendar day of the month.
- If Anthem requests additional information prior to making a new group determination, it should be received **within 7 business days** of the original request.
- If the information submitted is incomplete and subsequently not received in a timely manner, the group's application may be withdrawn for the month requested.
- It is the agent's responsibility to notify Anthem prior to approval if a change in the requested effective date is to be considered. A request for change will be required in writing from the employer.

Note: Effective date changes will not be accepted after approval.

Rating policies

- The premium is determined by the employer's principal business ZIP code.*
- For Small Group medical plans, rates are based upon individual age at the time of the group's effective date.
- For Small Group medical plans, the rate for a family is based on the combined rate of the employee and all dependents 21 and older, and up to the three oldest dependents 20 or younger.
- Dental products require SIC code to determine rate.
- Dental and vision rates are determined by the number of eligible employees.

Rate and benefit guarantee

- Medical rates are guaranteed for a minimum of 12 months. The anniversary month will determine the timing of future adjustments.
- Medical rates will adjust for age at renewal or if the anniversary date is changed.
- Dental and vision rates and benefits are guaranteed for 24 months or if the anniversary date is changed.

Completing forms

Please ensure all questions are answered and signatures and dates obtained.

- Only the employer may fill in, change, or modify the employer application.
- Only the employee may fill in, change, or modify the employee application.
- The employer application must be signed by the owner listed in the owner section of the employer application or an officer listed on the Statement of Information filed with the secretary of state of California.
- Whenever an individual has a language barrier and requires assistance to properly complete the application, the application must be submitted with a signed *Anthem Statement of Accountability* or *Translator Statement* from the group or the agent.

No alterations to preprinted materials will be accepted.

* 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.

Open enrollment period

Once a year, employers must give employees the opportunity to change plans or add dependents not previously enrolled. Employees and/or dependents who do not enroll when first eligible must generally wait until the annual open enrollment period to enroll. However, employees may be eligible to enroll themselves and their dependents before the next open enrollment period if a qualifying event, such as losing other coverage, occurs.

Medical plan participation

The group participation requirements are:*

- 60%: groups with 1–4 enrolled employees
- 25%: groups with 5-100 enrolled employees
- Minimum participation is 100% if noncontributory

The group must maintain the corresponding minimum participation levels in order to remain eligible for Small Group coverage. Groups are subject to cancellation or nonrenewal if participation falls below the required minimum to meet the definition of a small group.

Note: During the special open enrollment period (November 15 to December 15), participation requirements will not be enforced. The effective date will be January 1 of the following year.

For the purposes of calculating participation, the following are considered valid waivers, subject to receipt of an *Anthem Waiver* form and proof of other coverage (health plan ID cards), such as:

- Employer-sponsored group coverage through another employer
- Medi-Cal
- Medicare
- MediExcel
- United States military coverage
- Individual coverage on and off the exchange
- SIMNSA

Note: An owner of multiple entities will not be considered a valid waiver if the owner is declining due to coverage under another entity in which they hold ownership.

Dual coverage by the same employer would not be considered a valid waiver.

* Anthem may conduct periodic audits to confirm participation levels.

Medical plan names

- **Anthem Platinum** — provides the highest level of benefits, and employees often pay less when they receive care. However, platinum plans have the highest monthly premiums.
- **Anthem Gold** — provides richer benefits than the Silver and Bronze plans, and employees pay less when they receive care. However, the monthly premium is higher than Silver and Bronze plans.
- **Anthem Silver** — offers cost-effective monthly premiums, but compared to the Bronze plans, employees pay less when they receive care.
- **Anthem Bronze** — features broad benefits and the lowest monthly premiums, but employees pay more when they receive care. Deductibles, copays, and cost shares may be higher than with the other plans.

The metal structure represents actuarial values (AVs) and can be used to compare how overall cost sharing differs across plans. Minimum and maximum AVs for each type of plan include:

- Platinum 88%/92%
- Gold 78%/82%
- Silver 68%/72%
- Bronze 58%/62%



Product types

- **Preferred provider organization (PPO)** — allows members to go directly to any in-network care provider. There is no need to choose a primary care physician (PCP) or receive a referral to see other doctors.
- **Health maintenance organization (HMO)** — requires members to choose a PCP. A referral is required to see other doctors.
- **Health savings account (HSA)** — is a savings account for certain plans that members can fund with pretax dollars and use to pay for qualified healthcare expenses, including prescriptions. This is often used with a consumer-driven health plan.

Network options

PPO

- **Prudent Buyer PPO network** — offers access to more than 107,000 California doctors and specialists and more than 330 hospitals.
- **Select PPO network** — offers access to more than 73,000 California doctors and specialists and more than 320 hospitals.

Note: Employers may choose only one PPO network.

HMO

- **CaliforniaCare HMO network** — offers access to more than 63,000 California doctors and specialists and more than 330 hospitals.
- **Select HMO network** — offers access to more than 37,000 California doctors and specialists and nearly 330 hospitals.
- **Priority Select HMO** — offers access to more than 23,000 California doctors and specialists.
- **Vivity** — is a first-of-its-kind joint venture bringing Anthem and top-ranked health systems (such as Cedars-Sinai, Huntington Hospital, MemorialCare, PIH Health, Providence, Torrance Memorial, and UCLA Health) together. Vivity's goal is to deliver quality care, a member-first experience, and collaboration.

Note: Employers may choose only one HMO network. Employers must select a network for each plan type. For example, the employer may offer employees plans available in the Select HMO network alongside the Prudent Buyer PPO network. Not all network options are available in every area.

Enrollment in HMO networks is dependent upon the employee residing or working within a plan's geographic service area and the network provider, as well as physician availability within the geographical service area. If at the time of enrollment, the network or physician or 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 care provider, network, and/or plan.

Dental coverage

Dental Net DHMO

Available for 2–100 employees; a minimum of two employees must enroll:

- **Participation:** 2–100 eligible employees — 25% of eligible employees (a minimum of two employees must enroll).
- Dual-option offerings are available to small groups with at least five net-eligible employees, but the plans must have at least a 10% differential in premium rates. The 10% differential is calculated based on a comparison of the single rate for each quoted plan.
- Dual option is not allowed between two dental health maintenance organization (DHMO) plans. Dual option must be between an Anthem PPO and Anthem DHMO plan.
- Dual-option participation guidelines require a minimum of at least two 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

- **Participation:** 2–100 eligible employees — 25% of eligible employees (a minimum of two employees must enroll).
- A minimum of two employees must enroll in each non-orthodontia plan, and a minimum of five employees must enroll in each orthodontia plan. The two plans offered must have at least a 10% differential of the employee-only tier.

- Dual option with a DHMO must be with an Anthem DHMO.
- For PPO plans with orthodontia, a minimum of five employees must enroll.

Voluntary dental plans

Available for groups of 5–100 eligible employees:

- A minimum of two employees must enroll in the stand-alone dental products. There is no further participation requirement.
- Dual option is allowed with five or more employees enrolling in each option. The plans must have at least a 10% differential in premium rates based on the single rate. Dual option is not allowed between two DHMO plans. Dual option must be between an Anthem PPO and an Anthem DHMO plan, or between two Anthem PPO plans.

Eligibility guidelines

- The employer's principal business address must be in California.
- Seasonal and temporary employees are not eligible.
- Dental offices and clinics are not eligible.
- Changes to the definition of an employee are subject to Underwriting approval.
- Orthodontic coverage requires that five subscribers enroll.

Pediatric dental

All of our Small Group health plans include pediatric dental essential health benefits, which provide important coverage for children up to age 19. Benefits include preventive care; fillings; and more-extensive services, such as medically necessary orthodontia.

Vision coverage

Anthem now offers Blue View Vision.

Employer sponsored

- Available for 2–100 employees.
- A minimum of two employees must enroll.
- Dual option is available (an employer can select two plans to offer employees). An employer may choose a maximum of two plans but may not pair a voluntary plan with an employer-sponsored plan. Dual option requires at least 10 eligible employees. Two or more employees must enroll in each option.

Voluntary vision

Available for groups of 5–100 eligible employees:

- A minimum of two subscribers must enroll and choose a maximum of two plans.
- Dual option is available. An employer may choose a maximum of two plans but may not pair a voluntary plan with an employer-sponsored plan.
- Voluntary vision is available as a stand-alone product or in conjunction with medical and/or dental.

Pediatric vision

All of our Small Group health plans include pediatric vision essential health benefits, which provide coverage for vision exams and glasses or contacts for children up to age 19. Members can see a care provider in the Blue View Vision network, which includes retailers such as 1-800 CONTACTS®, LensCrafters®, and Target Optical®.

Adult exam only

All Small Group health plans include an adult exam-only benefit.

Contribution

Employers may choose their preferred approach for contributing to employee medical premiums. Payroll deduction is required, if contributory. Employers have the following contribution options:

Medical

- **Traditional:** a minimum contribution of 50% of each employee's monthly health premium.
- **Fixed dollar:** a fixed dollar amount $100 or greater (in $5 increments) for each covered employee's health premium.
- **Percentage and plan:** a minimum of 50% toward a specific plan, chosen by the employer.

Note: During the special open enrollment period (November 15 to December 15), contribution requirements will not be enforced. The effective date will be January 1 of the following year.

Premium-only plan (POP)

POP is an IRS-approved change in the payroll process that allows employers to use pretax salary dollars to pay employees' share of benefit premiums. All employer sizes can take advantage of this special provision of Section 125 of the IRS code.

Note: The IRS prohibits certain individuals from participating in POPs:

- Sole proprietors
- Partners within a partnership, including LLC and LLP
- Owners of an S corporation

Establishing a POP arrangement through HealthEquity, Inc. is convenient. The cost of a POP is only $125 per year.

The group must submit a separate check for the POP premium, made payable to Anthem, along with the POP application. POP applications received less than 15 days before the requested effective date will cause a delay.

For more information about POP, contact HealthEquity at 800-876-7548 (8 a.m. to 5 p.m. CT) or go to ezpop.com. For tax advice, consult your tax adviser.

For complete details, download the *Employer's Guide to the Premium Only Plan*.

Note: The POP application cannot be processed until group medical, dental, and vision coverage have been approved. Therefore, the POP effective date assigned by HealthEquity may be later than the effective date of the group's medical, dental, and vision coverage.

Orientation/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, considering a group-imposed orientation and/or waiting period. An employer may impose a 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 an orientation period, but cannot exceed 90 days. In accordance with SB 1034, groups are responsible for ensuring that a group-imposed waiting period is consistent with Section 2708 of the Federal Public Health Service Act (42 U.S.C. § 300gg-7).

Waiting period options are:

- 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.*

The group's orientation and/or waiting period is applied to all employees in the group, with no exceptions for eligible employees. The employer has the option to waive the orientation and/or waiting period of all new hires at the initial group enrollments only.

Note: Dual waiting periods are not allowed.

Takeover provisions

Small Group takeover provisions comply with the following:

- A carrier providing replacement coverage of hospital, medical, or surgical expense or service benefits within 60 days from the date of discontinuance of a prior contract or policy providing benefits will immediately cover all employees and dependents who were validly covered under the previous contract or policy providing benefits at the date of discontinuance. They are within the definitions of eligibility under the succeeding carrier's contract and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of provisions of the contract relating to active, full-time employment or hospital confinement or pregnancy.
- For employees or dependents who are completely incapacitated on the date of discontinuance of the prior carrier's contract or policy and entitled to an extension of benefits pursuant to subdivision (b) of Section 1399.62, or pursuant to subdivision (d) of Section 10128.2 of the Insurance Code, the succeeding carrier is not required to provide benefits for services or expenses directly related to any conditions that caused the total disability.

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

Prior deductible credit/annual out-of-pocket maximum/dental benefit waiting period credit

- For new group submissions, Anthem provides credit for deductibles met under prior takeover group medical or prior takeover group dental coverage if proof of the actual dollar amount is submitted with the first claim. This provision does not apply to new hires.
- Credit for a pharmacy deductible is not available, except when the member's prior takeover group coverage was an aggregate plan (such as an HSA).
- Credit for the annual maximum out of pocket is not available, except when the takeover group is moving from Anthem Large Group coverage.
- Anthem provides credit for the dental benefit waiting periods if Anthem receives proof of 12 months of prior creditable dental coverage at enrollment and there is no lapse in coverage between carriers.

Federal regulations

- The Federal Tax Equity and Fiscal Responsibility Act (TEFRA); Department for Environment, Food and Rural Affairs (DEFRA); and COBRA legislation was enacted to regulate employee healthcare coverage. Based on this legislation and the limitations of the Anthem agreement, if a business employs, on average, fewer than 20 employees in a year and any employee becomes age 65, their primary carrier must be Medicare. For employees who are 65 years old and choose to retain their Anthem Small Group coverage, Anthem will apply contract benefits as a secondary carrier for Medicare benefits paid or payable.
- When a member is covered by both Medicare and Anthem and Anthem is secondary, the total benefit provided by Medicare and Anthem should equal but not exceed the benefits of group members who do not have Medicare coverage.
- **Anthem is secondary to Medicare when one of the following criteria is met:**
  - If a member is required to pay an additional premium for part of Medicare and chooses not to enroll in that part, Anthem will pay per contract benefits as primary.
  - If a member is eligible for part of Medicare that is premium free and chooses not to enroll in that part, Medicare would be considered primary and the member's Anthem plan would be secondary. Anthem will estimate Medicare's benefit prior to Anthem coordinating coverage for deductibles and coinsurance.
- **Anthem is secondary to Medicare when the following criteria are met:**
  - The employer has fewer than 20 employees and the member is age 65.
  - Members under 65 are eligible for Medicare due to a disability. Members are enrolled following the first 30 months of kidney dialysis treatments for end-stage renal disease (ESRD).
  - The employer is responsible for administration (within the guidelines established by the federal government for compliance by employer groups).

State regulations

Cal-COBRA (SB 719) became effective January 1, 1998. This legislation provides for the continuation of coverage for employees and eligible dependents for groups that employed fewer than 20 employees at least 50% of the working days in the previous calendar year. This law also applies to an eligible employer that wasn't in business during part of the preceding calendar year if the employer employed 2–19 employees for at least 50% of the working days in the preceding calendar quarter.

- COBRA — Participation in the employee's benefit plan, as well as coverage under whatever medical programs are provided by the employer to employees and their dependents, may be continued under a federal law known as COBRA for groups that employ 20 or more full-time-equivalent employees for at least 50% of the previous calendar year.
- Employers with a single employee are not eligible for Cal-COBRA.

Under California law AB 1401, Cal-COBRA provides continuation of coverage for groups of 2–19 eligible employees for at least 50% of the working days in the preceding calendar year.

An employee and/or eligible dependents are eligible for continuation of coverage under Cal-COBRA if coverage was terminated due to one or more of the following qualifying events:

- Death of the plan subscriber, for continuation of dependent coverage
- Employee's termination of employment or reduction of hours

- Spouse's divorce or legal separation from the subscriber
- Loss of dependent's status of enrolled child
- Subscriber becoming entitled to Medicare
- Loss of eligibility status of enrolled family member

Anthem is currently administering Cal-COBRA. However, brokers and agents are responsible for submitting Cal-COBRA questionnaires, applications, and remittance checks with new business.

Note: Cal-COBRA rates are 110% of the group rate.

Effective January 1, 2008, AB 910 amended the existing law to extend the continuation of coverage rights for overage dependents who are:

1. Incapable of self-sustaining employment by reason of physically or mentally incapacitating injury, illness, or condition.
2. Chiefly dependent on the subscriber for support and maintenance. The law sets out new notification timelines, and requires subsequent healthcare service plans and health insurers to honor continued coverage unless there is a demonstration that the child no longer meets eligibility requirements.



General underwriting guidelines for existing business

Benefit modifications

During your client's time with Anthem, they may find that they need to make changes to their group coverage or their demographic information. The following guidelines apply:

Group level

Anthem can process your group's benefit modification 30 days prior to the group's anniversary date.

- Adding or changing a medical plan will only be allowed at the group's anniversary.
- Groups must be paid up to the requested effective date.
- Adding or changing your dental and vision plans will be allowed at any time, but only once every 12 months, subject to Anthem guidelines.
- Employers can make contribution changes once in a 12-month period, subject to Anthem guidelines.
- Anthem must be notified of changes in company name, ownership, or tax ID number. Changes are subject to Anthem review and approval.
- Waiting periods can be changed once every 12 months but cannot be retroactive.

Note: Refer to the "**Benefit modification job aid**" on pages 19–21 to determine when each type of benefit modification may be requested and which documents must accompany your request.

Member level

- Covered members may move to a different product offered by their group at the group's anniversary month.
- A member can request a change in medical benefits by completing the Employee Application during the group's anniversary month.
- Plan changes may also occur with a qualifying event or special open enrollment.

Note: Electronic enrollment is Small Group's new standard for completing plan changes. They can also be submitted by:

- Completing the ***Small Group Renewal Medical Plan Change Request Form*** on the group's anniversary date.
- Sending a written request signed by the owner.
- Sending an email from the owner, officer, or designated representative to small.group@anthem.com.

Benefit modification job aid

Benefit modification	When eligible	Documents necessary
Add or change a medical plan	At a group's anniversary only	1. Letter or email from the group signed by owner/officer or renewal documents, if available 2. Employee applications for any new enrollments who are not currently enrolled, or renewal documents, if available
Add Dental Net (DHMO) for 2–100 **2–100 eligible employees:** 25% eligible employees (and a minimum of two employees) who are not covered under another dental plan are required to enroll. **Dual option:*** Must have at least five net-elligible employees. Plans must have at least a 10% differential in premium rates. The 10% differential is calculated based on a comparison of the single rate for each quoted plan. * Dual option must be between Anthem PPO and Anthem DHMO plans. Dual option is not allowed between two DHMO plans. Participation requires a minimum of at least two enrolling in each option.	First of the month following receipt of all documentation	1. *Specialty Benefit Modification* form 2. Employee applications for any new enrollments who are not currently enrolled, or renewal documents, if available 3. Dental Net (DHMO) office numbers 4. Waivers for declining employees
Add voluntary Dental Net DHMO 5–100 eligible employees* A minimum of two employees must enroll. There is no further participation requirement. * Dual option is allowed with five or more employees enrolling in each option. The two plans must have at least a 10% differential in premium rates based on the single rate. Dual option is not allowed between two DHMO plans.	First of the month following receipt of all documentation	1. *Specialty Benefit Modification* form 2. Employee applications for new enrollments who are not currently enrolled, or renewal documents, if available 3. Dental Net (DHMO) provider office numbers 4. Copy of agent quote: brokerportal.anthem.com/apps/ptb/login 5. SIC code required 6. Rates based on eligible employee count
Add Dental PPO for 2–100 **2–100 eligible employees:** Minimum of 25% participation and at least two employees must enroll. **Dual option:** Dual-option PPO plans (employer can select two plans to offer to employees) are available for employer-sponsored plans. A dual option is available if the group has at least five net-elligible employees, a minimum of two employees must enroll in each option, and the two plans offered must have at least a 10% premium differential of the employee-only tier premium.	First of the month following receipt of all documentation	1. *Specialty Benefit Modification* form 2. Employee applications for any new enrollments who are not currently enrolled, or renewal documents, if available 3. Copy of agent quote: brokerportal.anthem.com/apps/ptb/login 4. Rates based on eligible employee count 5. Waivers for declining employees
Add voluntary Dental PPO 5–100 eligible employees* A minimum of two employees must enroll in the stand-alone dental products. There is no further participation requirement. * Dual option is allowed with five or more employees enrolling in each option. The plans must have at least a 10% differential in premium rates based on the single rate.	First of the month following receipt of all documentation	1. *Specialty Benefit Modification* form 2. Employee applications for any new enrollments who are not currently enrolled, or renewal documents, if available 3. Copy of agent quote: brokerportal.anthem.com/apps/ptb/login 4. SIC code required 5. Rates based on eligible employee count
Add employer vision 2–100 A minimum of two employees must enroll. Participation requirements apply. A maximum of two plans may be chosen and cannot be paired with a voluntary vision plan. **Note:** Canceled Blue View Vision coverage can only be added back at anniversary date.	First of the month following receipt of all documentation	1. *Specialty Benefit Modification* form 2. Employee applications for any new enrollments who are not currently enrolled, or renewal documents, if available 3. Waivers for declining employees 4. Copy of agent quote: brokerportal.anthem.com/apps/ptb/login 5. Rates based on eligible employee count

Benefit modification	When eligible	Documents necessary
Add voluntary vision 5–100 A minimum of two employees must enroll. Participation requirements apply. A maximum of two plans can be chosen and cannot be paired with an employer-sponsored plan. **Note:** Canceled Blue View Vision coverage can only be added back at anniversary date.	First of the month following receipt of all documentation	1. *Specialty Benefit Modification* form 2. Employee applications for new enrollments who are not currently enrolled, or renewal documents, if available 3. Rates based on eligible employee count
Add part-time employee eligibility (medical, dental, and vision)	First of the month following receipt of all documentation	1. Letter or email from the group signed by owner or officer 2. *Employee Enrollment Applications* 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	Once in a 12-month period; effective first of the month following receipt of documentation	1. Letter or email from group's owner or officer requesting the change
Group demographic changes Name change with same owner and no new enrollments. Name change without EIN change, same owner, and no new enrollments.	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.) **Note:** Additional documentation and review may be required.
Group demographic changes Name change with same owner and no new enrollments. Name change with EIN change, same owner, and no new enrollments.	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.) 3. New employer application **Note:** Additional documentation and review may be required.
Name change Name change with new ownership and enrollment changes. Name change and EIN change with new ownership and enrollment changes.	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. New employer application 3. Employee applications for new owners along with the *Anthem Eligibility Statement* completed in full 4. Purchase Agreement, federal tax ID letter, fictitious business name filing (sole proprietorship or partnership), or amended Articles of Incorporation (corporations), or amended Articles of Organization (limited liability corp.) **Note:** Additional documentation and review may be required.

Benefit modification	When eligible	Documents necessary
Ownership change The name and tax ID remain the same.	First of the month following receipt of all documentation	1. Letter or email from group signed by owner or officer requesting the ownership change 2. New employer application 3. Purchase Agreement or amended Articles of Incorporation/ Organization 4. Employee application for new owner with *Anthem Eligibility Statement* (if owner is eligible)
Splits If the company maintains or inherits the same employees (covered prior to the split).	First of the month following receipt of all documentation	1. Letter or email from group signed by owner or officer requesting the name change 2. New employer application 3. Employee applications for enrolling in the new entity 4. Federal tax ID letter, fictitious business name filing (sole proprietorship or partnership), or Articles of Incorporation (corporations), or Articles of Organization (limited liability corp.) 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. *Anthem Eligibility Statement* for owners not listed on *Quarterly Wage and Withholding Report* 7. Copy of agent quote: brokerportal.anthem.com/apps/ptb/login 8. Initial payment **Note:** Additional documentation and review may be required.
Mergers If a company insured with Anthem is merging with another company also insured by Anthem.	First of the month following receipt of all documentation	1. Letter or email from owner or officer of surviving group explaining and requesting the change 2. New employer application 3. Legal documentation of the merger 4. The most recent *Quarterly Wage and Withholding Report* from each company, with the status of each employee 5. Employee applications for all new employees enrolling or declining coverage 6. *Anthem 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 merging with another company also insured by Anthem.	First of the month following receipt of all documentation	1. Letter or email from group signed by owner or officer explaining and requesting the change 2. Legal documentation of the acquisition 3. The most recent *Quarterly Wage and Withholding Report,* with the status of each employee 4. New employer application 5. Employee applications for all new employees enrolling or waiving coverage **Note:** Additional documentation and review may be required.

What to expect upon approval

In the coming days, Anthem will complete enrollments and begin issuing the group's documents. You will be able to review the group's information on the Producer Toolbox. Employees may begin using their benefits on their effective date, and the employer may access their group information on EmployerAccess.

For the employer:

- The group contact will receive their EmployerAccess login credentials.
- An email will be sent notifying the employer that the *Evidence of Coverage (EOC)* is available for download.
- A new enrollment package will be sent with required notices, the group contract, and specialty *EOCs*, if applicable.
- A personalized URL will be available with helpful group information.

For employees:

- ID cards for enrolled members and a welcome packet with instructions on how to sign up at anthem.com/ca.

The employer is responsible for distributing the *Summary of Benefits and Coverage (SBC)*, *Summary of Dental Benefits of Coverage (SDBC)*, *Evidence of Coverage*, and required notices. Employers may download the *SBC* or *SDBC* at sbc.anthem.com.

If you need assistance with your client's enrollment documents, please contact your Anthem representative or Anthem Enrollment and Billing at **855-854-1429** or small.group@anthem.com.



Anthem

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