Group Administrator Manual

Colorado Small Group
Employers (2-100)

ECOBR1839AEN Rev. 06/17

Thank you for choosing Anthem Blue Cross and Blue Shield

Dear Group Administrator:

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

Your satisfaction is our primary concern, so we designed this *Group Administrator Manual* to help you with questions about enrollment, billing, membership changes and other day-to-day administrative activities. You'll also find helpful resources online at www.anthem.com. Additionally, our Customer Service representatives are here to support you. Just call us toll free at 1-877-833-5734.

Welcome to Anthem, where our mission is to improve the lives of the people we serve and the health of our communities. We appreciate the opportunity to serve you.

Sincerely,

Mike Ramseier
President and General Manager — Colorado

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We're here to help from 8 a.m. to 5:30 p.m. Mountain time

Questions about ...	Contact	Phone/Fax/Email/EmployerAccess	Address
Premium billing	Membership	Off-exchange plans only: Phone 1-800-922-4770 Fax 1-855-750-2227 Email Small.Group@Anthem.com EmployerAccess	Anthem Blue Cross and Blue Shield P.O. Box 51011 Los Angeles, CA 90051-5311
Enrollment or applications	Membership	Phone 1-800-922-4770 Fax 1-855-750-2227 Email Small.Group@Anthem.com EmployerAccess	Anthem Blue Cross and Blue Shield P.O. Box 172405 Denver, CO 80217-2405
State Continuation, COBRA, HIPAA and/or Medicare	Membership	Phone 1-800-922-4770 Fax 1-855-750-2227 Email Small.Group@Anthem.com EmployerAccess	
Medical claims	Claims	Phone 1-800-833-5734	Anthem Blue Cross and Blue Shield P.O. Box 5747 Denver, CO 80217-5747
Dental claims	Dental services	Refer to number on back of ID card	Refer to number on back of ID card
Vision claims out-of-network only	Blue View Vision Customer Service	Phone 1-866-723-0515	Blue View Vision Attn: OON Claims P.O. Box 8054 Mason, OH 45040-7111
Life claims	Life Claims	Phone 1-800-813-5682	Anthem Life Claims Center P.O. Box 182361 Columbus, OH 43218-2361
Pharmacy (retail)	Anthem Blue Cross and Blue Shield	Phone 1-800-700-2533	Anthem Blue Cross and Blue Shield c/o Prescription Drug Program (Retail Pharmacy) P.O. Box 4165 Woodland Hills, CA 91365-4165
Pharmacy (mail order)	ExpressScripts®, a separate company	Phone 1-800-962-8192	Express Scripts Home Delivery Service P.O. Box 66558 Saint Louis, MO 63166-6588
Coverage while traveling	BlueCard®	Phone 1-800-810-2583	n/a
Forms and supplies			www.anthem.com

Go to www.anthem.com for access 24 hours a day, seven days a week.

We hope these self-service options will also be helpful

Internet

For comprehensive resources, please visit our website at www.anthem.com, log on for member information, or choose **Employers** and then follow the prompts.

Employers

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

General resources

Basic tools and information are easy to download and print:

- Employee applications
- Frequently asked questions
- Important phone numbers and addresses
- Additional tools and information as new updates occur

Account access through EmployerAccess

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

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

Please give us a call at **1-800-922-4770** to learn how EmployerAccess can streamline account administration for you.

Members

Private information is encrypted for security. It's only available by using a personal identification number (PIN), which the member selects to view:

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

Interactive Voice Response system

Our Interactive Voice Response (IVR) system guides callers to a Customer Service representative or automated self-service options through a series of instructions and prompts. The system includes voice recognition enhancements to guide callers based on their verbal responses. Touch-tone response features are also available.

To get started, have your employer group number available and call **1-800-922-4770**. You'll be prompted to say or enter your information. Then, simply select menu option 4 to access your group administrator options.

Welcome to Anthem Blue Cross and Blue Shield Small Group Services department

To continue in English	Press 1	To reach group enrollment and billing	Press 1	For questions regarding your group health insurance policy	Press 1	For existing group membership and billing questions	Press 1

You can also select from a variety of self-service options that allow you to:

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

About your billing

Billing cycle

You will receive an itemized monthly invoice from Anthem about one month before the invoice due date. The invoice will include the due date, total premium due, past due amounts and any fees that apply. Detach the coupon from the invoice and include it with your premium payment in the envelope provided. If you don't include the payment coupon, processing for your payment could be delayed. Remember that you can always make your premium payment online through EmployerAccess. (If you're not already registered for EmployerAccess, call us at 1-800-922-4770 for details.)

The group is responsible for checking the accuracy of each monthly invoice and for notifying Anthem immediately by calling 1-800-922-4770 if there are discrepancies. It is important that you pay the full amount of the premium listed on the invoice. Separate checks for each of your group's Anthem products are not required. All checks must include the group number as it appears on the billing statement. Payment is delayed when the group number is not listed on the check.

Important note: Subject to the grace period, Anthem must receive your group's payments on or before the due date shown on the invoice, or the premium will be considered delinquent. Subject to the grace period, your group policy is subject to termination if Anthem does not receive your payment when it is due. Please allow at least five days for mailing time when making your monthly payment. See your group contract for more details. When you use EmployerAccess to pay your bill online, payment is posted within 1 to 2 days during the business week. Paying online before the end of the grace period reduces the risk for the group being canceled for non-payment of premium.

Premium payments

Nonpayment of premiums due

Anthem reserves the right to discontinue your Small Group coverage for non-payment of your monthly premium. If you don't remit your premium payment on time, your Small Group policy will be terminated, effective as of the last day through which premiums have been paid. Failure to make your premium payment does not meet the notification requirements for canceling your Small Group coverage. Please see *Canceling group coverage* in the **Group requirements and maintenance** section for information about how to cancel your Small Group coverage. You are required to pay premiums during your group's final month of coverage. If reinstatement is approved, you will be required to sign up for automatic recurring payments through EmployerAccess. Exceptions must be approved by Anthem.

Note: See your group contract for more details.

Beginning May 1, 2017, online payment is the new standard for Anthem Blue Cross Blue Shield Small Groups.

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

To work with you more efficiently, we're moving away from a paper-based system of invoicing groups and accepting payments. Anthem will issue your group billing statements online and receive payments online through our EmployerAccess portal (employer1.anthem.com/wps/portal/eeaemployer). The group will receive an itemized monthly invoice from Anthem Blue Cross approximately one month before the invoice due date. The invoice will include the due date, total premium due, past due amounts, ACA fees and any other applicable fees.

Opting out

If you still need to pay by check or receive a paper bill, we can help you with that, too. Send an email with "Opt Out" in the subject line to: employeraccesssupport@anthem.com. Provide your group number, contact name, email address, phone number and reason for opting out of the electronic billing and payment process.

What you need to know

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

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

Premium payments (continued)

Adjustments to your bill — employee/dependent additions and deletions

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

Please do not adjust your premium payment with credit for deleted employees; pay your premium as billed. Payments not made "in full" will subject your account to termination. We strongly recommend that you submit deletions as they occur to Anthem for timely processing. Failure to submit eligibility change information in a timely manner could result in premium inaccuracies that the group and/or employee may not be able to recover. Credit for terminations will be reflected on your next scheduled billing statement after Anthem has processed the deletion(s).

Important note: **Please do not submit termination(s) with your premium payment.** If you do, the terminations may not be processed because they will go to the premium payment lock box, not directly to Anthem. Instead, please send terminations to the address, fax, email, or via Employer Access. Failing to pay your premium or submitting membership changes by marking your invoice does not meet the notification requirements for terminating an employee or dependent from your policy.

Preparing to mail your payment

What to include:	When to include it:
Write your group number on the face of the check.	Always
Send your coupon with your check.	Always

Where to mail your payment

To ensure that we receive and process your premium payment promptly, please follow the steps listed directly above under *Preparing to mail your payment*. Mail your check and the coupon only to **Anthem Blue Cross and Blue Shield, P.O. Box 51011, Los Angeles, CA 90051-5311.**

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

Pay with check by phone

You can also call **1-800-922-4770** and pay by phone from your checking or savings account. Payment is due to be posted to the account by the last day of the grace period. We will assess a $10 charge at the time the payment is taken.

Pay online

You can also make your premium payment online through EmployerAccess. There is no administrative fee for online premium payments. If you're not already registered for EmployerAccess, call us at **1-800-922-4770** for details. It takes 1 to 2 business days for online payments to post. Payment is due to be posted to the account by the last day of the grace period.

Administrative fees

We will assess an administrative fee when any of the events described below occurs. Once we assess an administrative fee, it is due and payable with your next premium. The assessment of any fee does not prevent the assessment of any subsequent or additional fees to a single premium.

- ***Reinstatement fee***
  If the group's policy is canceled for non-compliance with contract requirements, and then the group's policy is reinstated, we will assess 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.**
- ***Returned check fee***
  We will assess a $20 returned check fee if payment for all or part of the group's premium or for any administrative fees is returned unpaid for any reason by the payer's bank. If we receive a second returned check from the group in a 12-month period, the group must submit all future premiums in the form of certified funds. Remittances from groups with a certified fund requirement will be examined at our lock box before posting to ensure compliance with this requirement. The certified funds requirement may be removed after the group has re-established a timely payment pattern. If we receive a third returned check from a group in a 12-month period, the group's policy will be canceled automatically.

  Important note: If we receive a check with a stop payment, it will incur the same fees as a returned check and will be subject to the provisions of any other dishonored check.
- ***Check by phone fee***
  An authorized representative of the group can call 1-800-922-4770 and pay by phone from their checking, savings, business or personal account. We need a National Automated Clearing House Association (NACHA) form with authorized signatures on file to take a payment from a business account. We will assess a $10 charge at the time the payment is taken.

You can save up to $120 per year by signing up to pay your premium online.

The following are just a few of the new fees and taxes required by the ACA:

Comparative effectiveness research (CER) fee

This fee funds a new Patient-Centered Outcomes Research Institute which examines the effectiveness, risks and benefits of medical treatments. It applies to fully insured and self-funded employer groups, and took effect in October 2012. We pay the fee for fully insured customers, but self-insured (ASO) plans must pay their own CER fees.

ACA reinsurance fee

This fee will support the transitional reinsurance program that aims to stabilize premiums for coverage in the Individual market and lower the effects of adverse selection. It applies to fully insured and self-funded employer groups. The fee will be included in your monthly invoice.

ACA insurer fee

This annual fee funds premium subsidies for the health care exchanges and Medicaid expansion. It applies to fully insured employer groups only. The fee will be included in your monthly invoice.

Enrollment guidelines

Eligible employees

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

- ***Full time***
  A full-time employee must be actively engaged in the conduct of the employer's business, with a normal work schedule of 30 or more hours per week. Only those employees whose wages are reported for tax purposes under the group's federal tax identification number on a 1099 or a W-2 form are eligible for enrollment. Persons compensated on a 1099 basis may be eligible for coverage, but restrictions do apply. Please contact your authorized Anthem agent for additional information.
- ***Sole proprietors/partners/corporate officers***
  Sole proprietors, partners and corporate officers must be actively engaged in the conduct of the business on a full-time basis, with a normal schedule of at least 30 hours per week. Coverage may be available to employees working between 24-29 hours if such coverage is requested by the group.

Employees who live outside Colorado

Employees who live outside the state of Colorado may also be eligible for certain coverage.

Important note: Available plans for employees residing in other states may be different than for employees residing in Colorado. **Plans on the Blue Priority and Blue Priority PPO provider networks, are only available to employees who live in the areas of Colorado served by these networks.** Contact your agent or our Membership department for more information.

Residents of Hawaii

The state of Hawaii has specific benefit requirements for group plans. Anthem's pooled plans will not be modified to accommodate the requirements, which is why we cannot offer coverage to residents of Hawaii. **Hawaii alert:** Due to Hawaii legislation, all plan requirements of the state (Extra Territorial requirements) are the responsibility of the account and NOT the carrier. Please note that <Employer Group Name> must file a copy of their plan with the state of Hawaii. The state of Hawaii will review and determine if our plan(s) meet their requirements. If our plan does not meet the state's requirements, our best option for Hawaii employees would be for the broker to obtain direct quotes for these employees from Blue Cross and Blue Shield of Hawaii (HMSA). This would ensure that all the state requirements are met.

Ineligible employees

Part-time, temporary, substitute, contract, leased, retired and seasonal (defined as "employees hired with a planned future termination date") employees are **not** eligible for coverage.

Enrolling new employees

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

The application mandated by the state of Colorado must be filled out completely with signatures at all appropriate designations. To enroll a new employee, an *Employee Application* must be fully completed. We must receive the completed application after the employee's date of hire and before the earlier of the following: a) the last day of the month following the end of the group's waiting period, or b) the last day of the month in which the employee is eligible. Please note that there are **no exceptions** to these requirements. Failure to submit this application will result in returning the application to the employer and further delay in processing enrollment for the member. Incomplete applications will not be processed, which may cause a delay in the employee's coverage effective date. If we receive an application more than 45 days after the employee's eligibility date, the employee will be considered a late enrollee and coverage may be delayed until open enrollment, depending on the plan. (See *Late enrollees/open enrollment* in the **Enrollment guidelines** section).

The employer is responsible for ensuring that the Employee/Dependent Waiver of Coverage section of the Colorado Uniform Employee Application for Small Group Health Benefits is completed for any employees and/or eligible dependents who decline coverage. As explained in the *Evidence of Coverage*, late entrants may be subjected to a delayed effective date of coverage.

We recommend that you submit an application immediately after an employee is hired. Coverage will not begin before the applicable waiting period is completed.

You can also enroll a new employee (and dependents, if applicable) via EmployerAccess.

Important note: The employer is responsible for ensuring that an application for each eligible employee who is applying for or declining coverage is forwarded to Anthem in a timely manner. Failure to do so may cause coverage to be delayed for an employee, which may expose the employer to liability to the employee and Anthem. Remember that you can enroll eligible employees online through EmployerAccess. If you aren't registered yet for EmployerAccess, please call us at 1-800-922-4770 for details.

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
- The waiting period selected by the employer
- Late enrollee classification, as defined under HIPAA
- The date we receive the fully completed application

Effective dates are determined as follows:

- If we receive the fully completed application before the employee's waiting period is completed, the effective date will be the first day of the month following approval of the application and expiration of the waiting period.
- 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 that coincides with completion of the waiting period.
- If we receive the application more than 45 days after the employee's eligibility date, the applicant may be considered a late enrollee as defined under HIPAA, and the applicant's effective date will be delayed until open enrollment. See the evidence of coverage for additional details.
- Please note that all late enrollees will have to be enrolled during the group's open enrollment unless they have a qualifying event as defined under HIPAA.

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

Minimum essential coverage

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

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

What we require on applications

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

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

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

More about enrollment

Examples of effective dates for eligible employees

	Example 1 Employee submits application within time frame	Example 2 Employee submits application late
Hire date	4/3/16	4/3/16
2-month waiting period	6/30/16	6/30/16
Effective date	7/1/16	7/1/16
Completed application received	7/15/16	9/2/16
Effective date	7/1/16	Employee is eligible on the group's open enrollment date, which equals the group's anniversary date. The group must submit an application for this late enrollee at the group's anniversary enrollment period.

Examples of effective dates for eligible employees who decline coverage

	Example 1 No qualifying event	Example 2 Employee who has experienced a qualifying event
Hire date	4/3/15	4/3/16
2-month waiting period	6/30/15	6/30/16
Effective date	7/1/15	7/1/16
Declination of coverage received	8/15/15	8/15/16
Employer anniversary	3/1/16	3/1/16
Date of qualifying event	N/A	9/15/16
Completed application received	3/5/16	9/20/16
Effective date	3/1/16	First day of open enrollment 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 days of termination, coverage will resume with no lapse upon our receipt of a written request from the employer group. If the employee is rehired more than 31 days after the termination date, the employee is considered a new employee, subject to applicable group-imposed waiting periods and must complete a new Employee Enrollment Application. The group is responsible for notifying us immediately if an employee is rehired and will be continuing coverage.

Eligible dependents

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

- Lawful spouse.
- Any biological or legally adopted child (see *Enrolling eligible dependents* in the **Enrollment** guidelines section) of the subscriber or the subscriber's enrolled spouse, up to age 26.
- A stepchild of the subscriber or the subscriber's enrolled spouse.
- A child (ward) of the subscriber's enrolled spouse who is named the ward's permanent legal guardian.
- Grandchildren may be covered only if the grandchild is a permanent legal guardian of the grandparent who is enrolled under the group's plan. Proof of guardianship is required.
- The same-sex domestic partner of the subscriber is automatically eligible for health care benefits, however an employer may choose not to offer the eligibility. Any current employee who would like to add a same-sex domestic partner must complete an *Affidavit of Domestic Partnership* and include it with a *Colorado Uniform Employee Application*. The *Affidavit of Domestic Partnership* is only needed when domestic partnership is the qualifying event. It is not needed at new group enrollment or the open enrollment period.

More about enrollment

Enrolling eligible dependents

Type of dependent	Application for coverage or declining coverage must be received:	And must include (if requesting coverage):
New spouse Coverage will begin on the date of marriage. · Common law spouse: requires notarized Common Law Spouse Affidavit when the common law marriage spouse is not added at the initial group set up or at the group's open enrollment · Domestic partner: requires Domestic Partner Affidavit when the domestic partner is not added at the initial group set up or at the group's open enrollment	Within 45 days of new marriage	*Employee Application*
Newborn child Coverage of newborns is automatic **only** for the first 31 days following birth. Employees must request to enroll newborns. This needs to be done by completing an *Employee Application* **within** the first 60 days following birth. **Otherwise, coverage terminates at the end of the 31-day period.** Payment of claims for birth-related expenses is not an indication of continued coverage. The employee must request the addition of a new dependent.	Within 60 days of birth	*Employee Application*
	After 60 days of birth	*Employee Application* - subject to late entrant guidelines
Adopted child A child who is in the process of being adopted is considered a legally adopted child if Anthem receives legal evidence of intent to adopt or notification of physical custody. In this case, the subscriber or spouse has the authority to control the health care needs of the child or has assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption.	Within 45 days of adoption or the right to control health care	*Employee Application* Legal evidence of authority to control the health care needs of the child
Stepchild A child of the subscriber's spouse	Within 45 days of marriage	*Employee Application*
Ward of a permanent legal guardian An unmarried child (ward) of a subscriber or the subscriber's enrolled spouse, who is named the **permanent** legal guardian by a final court decree or order, will be considered an eligible dependent child, subject to all rules and age limitations that apply to an eligible dependent child.	Within 45 days of issuance of the final court decree or order of legal guardianship	*Employee Application* Letter of Guardianship form from the court, showing the filing date and court seal
Grandchild(ren) With proof of permanent legal guardianship or adoption.	Within 45 days of issuance of the final court decree or order of legal guardianship	*Employee Application*
Late enrollee dependents Dependents are considered late enrollees if coverage is not requested within the required time frame: · If we receive the completed application more than 45 days after the eligibility date, the dependent may be considered a late enrollee under HIPAA, and depending on the plan, the effective date of coverage may be delayed. · Only those employees/dependents enrolling late due to a qualifying event will be added off the group's anniversary enrollment period.	During the group's open enrollment period (Anthem anniversary) Before conditions that would otherwise cause a dependent to be a late enrollee	*Employee Application* Proof of qualifying event

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

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

More about enrollment

Declinations

New employees who don't elect coverage or existing employees who choose to discontinue coverage under the employer's Anthem Small Group policy must complete the Employee/Dependent Waiver of Coverage section of the Colorado Uniform Employee Application for Small Group Health Benefits. We must receive the application after the hire date and before the last day of the month following the end of the waiting period selected by the group. The employer is responsible for ensuring that Anthem receives applications from employees who are declining coverage within the same time frame as applications from employees who are requesting coverage (see the *Enrolling new employees* subsection). Depending on why an employee chooses to decline coverage, he or she may be eligible to reapply at a later date. If an employee applies after the eligibility period has expired and we did not previously receive a declination, the employee may be considered a late enrollee and be subject to late enrollee guidelines.

Late enrollees/open enrollment

If Anthem receives a new E*mployee Application* more than 45 days after the applicant becomes eligible, the subscriber and eligible dependents will be considered late enrollees and may be exposed to delayed effective dates.

Late entrants may enroll only during the employer's annual renewal enrollment period. This is known as "open enrollment." Late entrants applying for life and disability coverage will be subject to medical underwriting.

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

Where to submit applications

Submit all completed Employee Applications to one of the following:

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

Fax: **1-855-750-2227**

Email **Small.Group@Anthem.com**

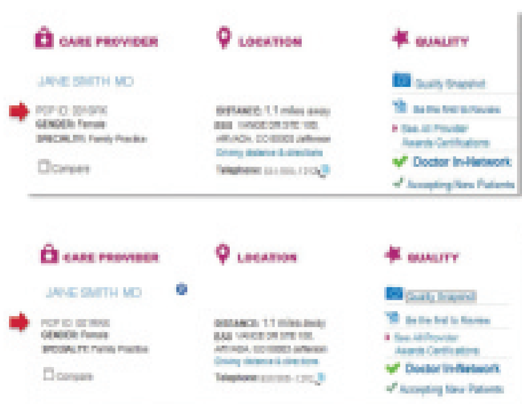
You can also enroll your members and their dependents online at www.anthem.com and register online for EmployerAccess. Please call 1-800-922-4770 to get started.

Choosing a PCP

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

To find a provider number, please follow these instructions:

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



PCP IDs vary based on network. In the above example, the PCP ID 001GFK for Jane Smith MD is for the Anthem PPO network. Her PCP ID changes to 001RRX for the Pathway network.

Employee application tips

- Use black ink and print clearly and legibly.
- Include your Small Group number at the top of the application.
- **Make sure all required areas of the form are completed.**
- A primary care physician (PCP) is required on all plans.
- All requests for information must be completed and returned promptly. Coverage may be denied if we don't receive the employee application within applicable time frames.
- Social Security or ID number(s) are required.
- The employee must either enroll or decline coverage for all eligible dependents.
- Information on previous coverage is critical; be sure to submit proof of prior coverage (if applicable) and provide a copy of a Medicare ID card (if applicable).
- The application *must be signed and dated* by the subscriber in Terms and Conditions.
- Employees who request life insurance must name a beneficiary.
- Incomplete applications may be returned, which will delay the coverage effective date.

Enrollment actions guide

	How this action can be done:			
Action	**Internet EmployerAccess**	**Employer Application**	**Employee Application**	**Comments**
Add a new employee and/or dependents to the plan	x		x	Additional documentation may be needed, depending on the type of dependent.
Add dependents for an existing employee	x		x	
Decline coverage for an employee and/or dependents			x	The Employee/Dependent Waiver of Coverage section of the Colorado Uniform Employee Application for Small Group Health Benefits must be completed.
Change plans for employees or dependents who already have coverage			x	Changes can only be requested on the group's anniversary date.
Terminate an employee and/or dependents from the plan	x			Notify Anthem immediately upon termination.
Discontinue coverage for employees and/or dependents who still remain eligible under the plan	x		x	An *Employee Application* must be completed to avoid delays if coverage is selected at a later date.
Change an employee's address	x		x	The employee can also call Customer Service directly to make this change.
Notify us about a COBRA or State Continuation qualifying event for an employee and/or dependents already enrolled in the plan				Complete the COBRA/State Continuation application.
Remove a subscriber from federal COBRA	x			Complete the COBRA/State Continuation application.
Change the employer's address		x		You can also submit a written request on the employer's letterhead, signed by an owner/officer of the company. This type of change requires a Secretary of State filing to support the change to the address and these changes are subject to UW approval, if rates are affected.

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

Membership changes

Canceling employees from the plan

Use the *Employee Application* to send the request to cancel the employee. Employees may be canceled due to termination of employment, ineligibility for coverage under the plan, or when the employee wants to discontinue coverage regardless of his/her employment status and/or eligibility. An employee's coverage under the plan must be canceled if:

- Employment is terminated.
- An eligible full-time employee changes to a part-time employee.
- An employee is on a leave of absence (medical and/or personal) and the time period that the employer covers employees on leave has expired.
- An eligible employee becomes ineligible by becoming a temporary, substitute, seasonal, leased or contract employee.
- An employee otherwise becomes ineligible to participate in the plan.
- The employee no longer wants to continue federal COBRA or State Continuation Coverage.

Please see page 26 for information about canceling employees from life insurance plans.

Canceling terminated employees

To cancel a terminated employee, please fill out an application or send your request in writing. Please send the termination in as it occurs. **We cannot retroactively cancel members/dependents in the State of Colorado according to HB1353**. If the member/dependent is eligible and requests continuing coverage in COBRA or State Continuation, please

forward the completed application to Anthem. Both terminations and subsequent applications for continuing coverage can be faxed to 1-855-750-2227 or mailed to:

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

Or email to: Small.Group@Anthem.com or via EmployerAccess

Please do not include any correspondence with your monthly payment.

Please note: Retroactive cancellations are not allowed per Colorado HB1353.

If you fax or email the termination documentation, you don't have to mail the originals to us. Employers are required by law to allow employees to remain on the plan until their employment is terminated. Cancellation of the terminated employee's coverage will be effective as of the last day of the month in which we receive notification of the termination. Timely notification of terminations is required to ensure that coverage does not extend beyond the month when the termination occurred and to comply with COBRA and State Continuation notification requirements. When notification is delayed, we are unable to cancel coverage in a timely manner, which results in continued coverage for ineligible employees and dependents.

Important note: When a member's employment is terminated, the employee must be canceled from the group. After Anthem is notified about the COBRA election, the member will be enrolled under the group's COBRA benefits. **The employer is obligated under law and by contract with Anthem to notify employees of their cancellation of coverage and of any rights to continue coverage. Failure to do so exposes the employer to liability to the employee and to Anthem. When preparing your monthly premium payment, please do not delete any premiums for canceled members. A credit for the cancellation will be reflected on a future billing.**

Canceling employees who remain eligible, but discontinue coverage

Please indicate the following information in a request: identification number, employee and/or dependent names, which coverage is being canceled, the reason for coverage cancellation and the effective date.

Please remember that the Employee/Dependent Waiver of Coverage section of the Colorado Uniform Employee Application for Small Group Health Benefits must be completed for those employees who are still employed but canceling coverage.

The employer must provide written instructions and submit it with the *Employee Application* to Anthem. Cancellation of the employee's coverage will be effective as of the last day of the month in which we receive notification of the termination.

Canceling employees who remain eligible but discontinue coverage (continued)

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

Canceling COBRA members

COBRA members are subject to the same grace period as the group, except for the first premium payment, which has a 45-day grace period. The group is responsible for canceling COBRA members in a timely manner if payment is not received within the specified grace period. **Do not wait for COBRA/State Continuation election to take place before submitting cancellation requests for employees. We do not accept retroactive cancellations beyond the original grace period.**

COBRA-eligible dependents

If a dependent becomes eligible for COBRA, please complete the COBRA/State Continuation application and submit it to Anthem. A dependent is eligible when the subscriber divorces, the subscriber dies, a dependent child becomes over age or the subscriber becomes eligible for Medicare.

The employer is responsible for notifying Anthem in a timely manner about changes in group size that cause changes in the group's Medicare and COBRA status.

Employees turning 65

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

Extension of continuation benefits

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

Over-age dependents

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

To be eligible for this coverage, children do not need to be:

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

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

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

If the requested coverage is due to a court order: We must receive a copy of the court order or receive a request from the district attorney, either parent or the person who has custody of the child, the employer or the group administrator. We will request information that the child meets the coverage criteria, and the subscriber must submit the information within 60 days of receiving our request. Anthem will determine if the child meets the criteria for coverage. An application for coverage must be submitted to Anthem within 30 days from the date the court order is issued. We may request information about the dependent

child initially, and then no more frequently than annually, to determine if the child continues to meet the coverage criteria.

To replace other prior coverage with Anthem coverage: We will request information that the child meets the applicable coverage criteria. The subscriber must submit that information within 60 days of receiving our request. We will then determine whether the child meets the criteria for continued coverage. We may request information about the dependent child initially, and then no more frequently than annually, to determine if the child continues to meet the applicable criteria for coverage.

Balancing employee choice and employer control

An overview of comprehensive coverage

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

- **Health** – start with a strong foundation
- **Dental** – add even more value
- **Vision** – build a clearly superior benefits package
- **Life** – provide security and peace of mind

Health coverage

We offer a varied selection of health plans in these five categories:

- **Elements** - our value plans
- **Classic solutions** - traditional preferred provider organization (PPO) copay plans
- **Consumer-driven** - our health savings account (HSA) suite
- **High performance** - health maintenance organization (HMO) and PPO options based on the Blue Priority network
- **Focused** - our HMO Pathway offering

Dental Prime and Dental Complete coverage

By offering dental coverage to your employees, you add value to their benefits package.

- ***Integration:*** Members who are pregnant or living with diabetes can receive one additional dental cleaning or periodontal checkup each year.
- ***Network:*** Access to more than 100,000 dentists and specialists nationwide. We offer different sizes of networks that allow your employees to control costs without reducing benefits.
- ***Additional features:*** Our plans include these unique member features: 100% in-network preventive care to keep employees healthier and more productive.
  - More discounts beyond annual maximum.
  - Wide range of annual maximum options including annual maximum carryover.
  - Variety of plan designs.
  - Orthodontia options available for groups with 5+ enrolling subscribers.
  - A benefit for brush biopsy to help diagnose cancer in time for treatment.
- ***Service:*** With more than 40 years of dental administration experience, the consistency of our U.S.-based customer service operations exceeds service standards.

Vision coverage

With Blue View Vision℠, you can offer a cost-effective, comprehensive plan to meet your employees' vision needs. Our Blue View Vision plans include:

- Comprehensive eye exams and fast delivery of eyewear.
- A statewide network that includes an extensive selection of optometrists and ophthalmologists, as well as retail locations such as 1-800 CONTACTS®, LensCrafters®, Pearle Vision®, Sears Optical℠, Target Optical®, JCPenney® Optical and separate companies offering vision-related services.
- Retail savings of 15% to 40% (beyond plan benefits) on unlimited purchases of extra pairs of eyewear, nonprescription sunglasses and other popular accessories.

More about coverage options

Life coverage

Life coverage is an important — and inexpensive — way to help your employees protect their families' financial future. You can offer several types of coverage to your employees, including basic term life, dependent life and supplemental life. These coverages are underwritten by Anthem Life Insurance Company.

- Basic term life coverage is available to groups of 2-100 and includes accidental death & dismemberment (AD&D) benefits. Groups of 2-9 may apply for one of three options: $25,000, $30,000 or $50,000. Groups of 10-19 may apply for the same three as 2-9 groups plus $100,000. Groups of 20+ may apply for a flat amount between $25,000 to $300,000.
- There are several dependent life coverage options based on the number of enrolled employees. Employer contribution isn't required.
- Optional supplemental life is also available. Employer contribution isn't required.

Composite rates

All new groups of 10 or more enrolling employees automatically get the advantage of composite life rates. This means that employers receive a single rate per $1,000 in life coverage, regardless of the age or gender of those enrolling.

Summary of Benefits and Coverage (SBC)

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

Here's how to get the SBC for your Small Group fully insured plan:

13. Go to **sbc.anthem.com**.
14. Start by:
    a. Selecting your status
    b. Select **Next**
15. Plans are found by choosing various data elements. This is our recommendation:
    a. Plan name (full or partial)
    b. State
    c. Market (for example Small Group)
    d. Appropriate coverage effective date
16. After choosing your elements, select **Search**.

The more descriptive you are, the fewer results will be returned. Enter a partial plan name to view more plan options. Or eliminate data elements to broaden the search.
For example, enter any key word or phrase: Entering "Anthem Platinum Select PPO" will return any plan match with "Anthem Platinum Select PPO"in the name.

17. Select the plan by selecting the down arrow icon.
18. The SBCs will be distributed based on the information provided (screen will be different based on status selected). Select **View**.
19. Select **Save** on the pop-up box. Save to the desired location on your computer.
20. Open from the location on your computer (screenshot not shown), and print or attach to an email (if electronic distribution criteria are met) to distribute the SBC.

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

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

Group requirements and maintenance

Accurate information

For Anthem to effectively administer your group's benefits, you must submit timely, accurate information related to eligibility changes. This includes notifying us about new employee or dependent additions, changes in plans, terminations, address changes, leaves of absence, COBRA and State Continuation notices, Medicare eligibility and individuals turning age 65. The employer also must notify Anthem about changes that affect the group. These changes include, but are not limited to, an address change for the company, change in company ownership, change in group administrator, an acquisition or merger of or by another company or business entity, and a change in the number of persons employed by the company when such a change may affect the group's COBRA, State Continuation or Medicare payee status. You must submit information about these and other events within the time frames that are outlined in your *Combined Evidence of Coverage* and *Disclosure Form/Certificate*.

Important note: Failure to provide updated eligibility information may result in delays in coverage or premium inaccuracies that the group or the employee may not be able to recover.

ID cards and certificates

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

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

Employee participation requirements

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

To calculate employee participation, start with the total number of employees, including the company's owner(s). Next, subtract the number of employees with allowable waivers (for example, employees with Medicare/military, those covered as a dependent on a spouse's or parent's employer-sponsored group plan or have Individual coverage). The result indicates the total number of eligible employees. Now you have the total number of eligible employees. Finally, divide the number of eligible employees by the number of eligible enrolling employees. The resulting percentage indicates the group's participation. (See below for an illustration of how to calculate employee participation.)

The example below shows how employee participation may be calculated for a small business (including the owner).	Health coverage
Total employees	**30**
Waive those who don't participate for allowable reasons - Employees with military coverage - Employees covered by spouse's employer group plan - Employees covered by parent's employer group plan - Employees covered by other employer-sponsored HMO plan - Employees who want to keep existing Individual plan coverage	 -1 -1 -4 -2 -1
Eligible employees	**21**
Subtract those who don't participate for other reasons - Employees who simply don't want to participate	 -3
Eligible enrolling employees	**18**
Participation percentages	**86%**

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

Please see the following that outlines the participation requirements:

- Health participation is now 1-19 ELIGIBLE employees 70%, 20-50 ELIGIBLE employees 60% and 51-100 ELIGIBLE employees 50%.
- Dental participation is now 2-4 enrolled 100% participation, 5-14 enrolled is 70% participation, 15-10 enrolled requires 60% participation and 51+ enrolled requires 50% participation.
- Voluntary Dental only requires a minimum of 5 employees be enrolled.
- Vision sold alongside medical and/or dental must meet the same participation as medical with a minimum of 50%.
- Voluntary Vision requires 5 employees be enrolled.
- Life and Disability require 75% participation while Dependent life requires 50% of employees with dependents take the coverage.

Special provisions

- If the employer pays 100% of the employees' health, vision, dental, and/or life premiums, then 100% of the eligible employees must participate.
- Supplemental life participation requirements vary by group size: For groups of 2-3, 100% participation is required; for groups of 4-10, at least three eligible employees must participate; for groups of 11-100, 25% participation is required.

Employer contribution requirements

Before January 1, 2015: Employers can share monthly premium costs with their employees. The employer chooses a contribution option and pays at least a minimum amount of each employee's monthly premium (dependent contributions are optional). Employees cover any remaining premium balance themselves through payroll deductions.

	Employer contribution options	
Type of coverage	**Traditional** (percentage applied to all plans employees are enrolled in)	**Fixed dollar** (dollar amount applied to all plans employees are enrolled in)
Health	Employers may choose to contribute to an employee's and/or employee's dependents' health premium cost by either a traditional option (percentage of premium) or a fixed-dollar option (defined amount for all employees)	
Vision	Employer-paid vision requires 50% contribution.	N/A
Dental	Employer-paid dental requires 50% contribution. If purchased with medical, dental contribution drops to 25%.	
Life	Group term life: 25% minimum employer contribution supplemental life: no employer contribution required	

*25% on vision if chosen with health plans.

**Certain restrictions apply.

More about group requirements and maintenance

Anniversary dates

An employer's anniversary date is the month and day when the group's policy became effective and coverage started. **Unless specifically authorized by Anthem, the group's anniversary date cannot be changed.** The group's anniversary date is important because there are certain actions and changes that can occur only on that date. These activities include the following:

- Change from one type of plan to another type of plan that the employer already offers
- Request to add employees and/or dependents who previously declined coverage

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

Employer waiting periods

New and renewing groups cannot have a waiting period greater than 90 days. The employer selects the waiting period, which is the period of time that must pass between an employee's hire date and the date the employee is eligible to enroll or decline to participate in the employer's benefit plan. The employer can choose a waiting period of the first of the month following one or two months or the hire date which is the first of the month following the employee's hire date. The first available effective date for new employees is the first day of the month following or coinciding with the month when the waiting period expires.

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

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

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

Canceling group coverage

If you decide to discontinue the group's coverage, please notify Anthem immediately in writing at least 31 days before the requested cancellation date. Premiums must be paid through the requested cancellation date. The written notice must be on company letterhead and be signed by an owner/officer of the company, group administrator or broker of record. The employer is responsible for notifying employees in a timely manner when coverage has been canceled.

Nonrenewal of coverage

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

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

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

Changes in ownership

Anthem must be notified in writing about any changes in the company's ownership. The written notice must contain full details, including a copy of the buyout agreement, sale of assets agreement or other agreement that resulted in the change. Continued coverage for the group as a result of these changes is subject to underwriting review and approval. If the company's new owner chooses to join the plan, a new underwriting review may be required, which could affect premium rates. Anthem also must be notified if the name of the company or its federal tax ID number changes. Your group benefit agreement is not assignable or transferable and it may not, among other things, be transferred as part of a sale of the assets of the business. These changes must be submitted directly to the Small Group Underwriting department. The fax number is 1-303-764-7047.

Address changes

We recommend that you submit company and employee address changes to us in writing. Only the group's authorized representative, the employee or the broker can initiate an employee address change. Please submit employee address changes on a *DORA Application.* You can also submit employee address changes online through EmployerAccess. (If you haven't registered for EmployerAccess, please call us at 1-800-922-4770 for details.) Please note that address changes may affect the available plan selections and current rates, so it's important to notify Anthem about these changes in a timely manner. And although we recommend that you submit employee address changes in writing or online, you can also do so over the phone. Submit an employer address change on an Employer Application or on company letterhead with the signature of an owner/officer of the company. This type of change requires a Secretary of State filing to support the change to the address and these changes are subject to UW approval, if rates are affected.

Leaves of absence

Short-term personal leave of absence

The employer determines the length of time, up to three months, that health benefits will remain in effect under the plan if an employee takes a short-term personal leave of absence. If approved by the employer, enrolled employees are eligible to continue group coverage for themselves and their enrolled dependents for the period of time. Monthly premiums will continue to accrue during an employee's short-term personal leave of absence, and the employer must continue to pay the required monthly premiums. However, the employer can request that the employee pay the premium during this period.

Please note that Anthem has no obligation and the employer has no right to continue coverage during an employee's short-term personal leave of absence for longer than the period indicated in the group's application. After the time period for continued coverage expires, an enrollee can elect to continue coverage under COBRA or State Continuation, as applicable.

Benefit modifications

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

- Adding a health, vision, dental, or life plan
- Changing to a different health, vision, dental, or life plan
- Changing the employer contribution level
- Adding dependent coverage
- Changing the group's waiting period, which cannot exceed 90 days, and has not been changed in the last 12 months

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.

Depending on the type of benefit modification requested, underwriting may be required. Certain supporting documentation is required to review a request to modify benefits, and it must be complete and accurate before we can process the request. We must receive the completed documentation, including all necessary Anthem forms, at least **31 days** before the requested effective date. If the benefit modification is approved, our Underwriting department will determine the effective date for the benefit change.

Benefit modification job aid

The group can request coverage changes at specific times by submitting the required forms and documentation, which must be accurate and complete. We must receive the required information at least **31 days** before the requested effective date. Depending on the change requested, underwriting approval may be required. If the benefit modification is approved, our Underwriting department will determine the effective date for the benefit change. Below is a chart with information about specific types of benefit modifications, eligibility and required documentation.

Requested change	When eligible	Required documents
Add available dental coverage	First of the month following receipt of all documentation.	*1.* *Employer Application*, or 2. Letter from the group. 3. Colorado Wage and Quarterly Report, reconciled by listing all employee's current employment status **or** a letter stating that the group wants to match current medical enrollment 100%. 4. The *Employee Enrollment Supplemental Application* is required for all eligible employees to enroll or decline dental coverage. This requirement is waived if the group matches dental enrollment to the medical enrollment 100%.
Add available vision coverage	First of the month following receipt of all documentation.	*1.* *Employer Application*, or 2. Letter from the group. 3. Colorado Wage and Quarterly Report, reconciled by listing all employee's current employment status **or** a letter stating that the group want to match current medical enrollment 100%. 4. The *Employee Enrollment Supplemental Application* is required for all eligible employees to enroll or decline vision coverage. This requirement is waived if the group matches vision enrollment to the medical enrollment 100%.
Add life insurance or increase existing coverage	First of the month following receipt of all documentation	*1.* *Employer Application*, or 2. Colorado Wage and Quarterly Report, reconciled by listing the employees' status. *3.* *Employee Applications* for all eligible employees to enroll or waive life coverage. If the group is applying for an amount over guaranteed issue, health statements will be required.* (subject to Underwriting approval)

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

* All new employees are required to submit a completed application.

More about group requirements and maintenance

Continuation of coverage

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

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

State Continuation Coverage

Colorado State Continuation coverage is available for up to 18 months for an employee, for an employee's spouse and dependent child(ren). An employee who voluntarily leaves his or her employment, and the spouse and dependent child(ren) of that employee, are eligible for State Continuation coverage.

Continuation coverage is available if an employee was continuously covered by your group's plan for six consecutive months. Premiums are paid directly to Anthem on a monthly basis.

Election period: Employee shall notify the employer, in writing, of their intent to continue coverage and submit premium payment to the employer within 30 days of termination. If the employer fails to notify the employee of the right to continue, the employee has the option of retaining coverage by making proper payment to the employer within 60 days of the date of termination. Within 10 days of termination, employer must send written notice to employee of right to continue. The notice must inform the employee of the amount the employee must pay monthly to the employer to retain coverage; how, where and when payment is to be made; and the fact that loss of coverage will result if timely payment is not made to the employer.

COBRA

Employees whose employment has terminated may continue to participate in the employer's benefit plan, as well as in whatever health care plans the employer provides to employees and their dependents, under a federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA applies to groups that employ 20 or more employees for at least 50% of the previous calendar year. For the purposes of COBRA compliance, the employer is responsible for COBRA administration under this federal law. Anthem isn't responsible for COBRA administration. The employer is responsible for providing satisfactory notice to employees about COBRA benefits, as well as disclosure and other administrative obligations imposed under Employee Retirement Income Security Act of 1974 (ERISA). Eligible former employees have 60 days from the date of termination to decide if they will continue benefits under COBRA. Use the COBRA/State Continuation application to enroll an employee and if applicable, their dependent(s). Please note the periods of notification and election as stated by law.

Medicare Part D

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

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

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

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

For samples of coverage notices, please go to the CMS website at **cms.hhs.gov/medicarereform**, and then choose the **Creditable Coverage** link, or call Medicare at **1-800-633-4227**.

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

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

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

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

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

Please note

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

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

Additional information

For more information on the requirements, please refer to the CMS website at cms.hhs.gov/MandatoryInsRep.

What you need to provide

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

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

How to submit your data

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

Email submissions

For a secure transmittal of information to us via email, we provide the use of our secure email. Please capture the required data fields as indicated in the enclosed templates, which can be downloaded from http://group.anthem.com/mspform. To submit your group and/or member eligibility data, visit messages.anthemsecureemail.com. You will go through a one-time account creation process to create an account with a personalized username and password. After having done so, you can use the site.

Tape/electronic submissions

If you currently provide eligibility data via tape/electronic transfer, please include subscriber, spouse and domestic partner SSNs/HICNs on your existing files. For valid group size and valid TIN/EIN, please download the group eligibility data template from http://group.anthem.com/mspform and send the completed form via the secure email process to the account email address stated above.

Paper submissions

If you prefer to mail your eligibility data to us, please use the enclosed pre-addressed envelope. Please download the enclosed templates from the site, capture the required data fields, and mail the template(s) to us to ensure the SSNs/HICNs, group size and TINs/EINs are appropriately captured on our systems. If you are unable to download the templates, please capture the required data fields in an Excel spreadsheet. Due to the sensitivity of the data, we encourage you to take the necessary precautions to secure and protect your information. We suggest that you use a mail vendor with tracking mechanisms in place when sending your data.

HIPAA (Health Insurance Portability and Accountability Act)

Terminated employees and/or their dependents and employees and/or their dependents who have exhausted or are not eligible for COBRA or State Continuation coverage may be able to continue coverage with one of Anthem's Individual off-exchange plans.

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

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

Conversion

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

About claims

Filing a claim

To claim benefits, a member must submit a properly completed claim form that itemizes the services or supplies received and the applicable charges. All claims should be submitted to the address on the member's ID card.

Coordination with Medicare

Your group's Anthem Small Group plan **does not** 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 (DEFRA) requirements, an Anthem medical policy is the primary payer for businesses with 20 or more employees, regardless of how many enrollees are covered under the plan. For groups with fewer than 20 employees, Anthem is the secondary payer to Medicare and does not duplicate benefits that might be available under Medicare. Anthem determines its benefits, subtracts them from the benefits that are paid or payable under Medicare and pays the difference. Anthem is the primary payer when a group employs more than 100 employees and the Medicare recipient is disabled and under age 65.

Anthem will not provide benefits that duplicate any benefits a beneficiary is entitled to receive under Medicare. This means that when Medicare is the primary health coverage, we provide benefits in accordance with the benefits of the Anthem plan, less any amount paid by Medicare. Medicare Part A and Part B beneficiaries will be eligible for nonduplicate Medicare coverage, with supplemental coordination of benefits. However, if they are required to pay the Social Security Administration an additional premium for any part of Medicare, then the above policy only applies if they are enrolled in that part of Medicare.

The employer is responsible for notifying Anthem about changes in group size that also change the group's Medicare and COBRA/State Continuation status.

Improve the health of your employees and your business with programs that identify and engage

Lower costs, higher productivity

Good employee health is good for your business. By helping employees improve their health, Anthem helps improve productivity, reduce costly absenteeism, lower expensive medical claims and control health care costs for you.

Something for everyone

Each of your employees is unique. One may be in peak physical shape while another may struggle with chronic conditions. Some may neglect their health while others spend hours at the gym. We connect them all with the programs, tools and resources that help fit their individual needs.

- Live nurse coaches for personalized guidance
- Proactive care for potential health issues before they become more serious and costly
- Discounts on products and services that encourage healthy lifestyles, such as weight-loss programs and fitness equipment
- Online health and wellness information and interactive tools

Proactive support

We work proactively to assess each member's health status and engage him or her with appropriate programs. Individual needs are identified through medical, pharmacy and disability claims; lab, dental and vision data; referrals from physicians and our 24/7 NurseLine nurses; self-referrals; health risk assessments; and more. Then we engage them with everything from personalized messages by mail to personal phone calls from a Nurse Coach. Often, we reach out to members with the help they need, even before they know they need it.

Connecting employees to better health

At Anthem, we believe that people who practice healthier lifestyles generally live longer, more active lives. But, no matter how we choose to live, we could all use a little help.

Health and wellness resources and tools

- www.anthem.com — A wealth of health information and tools, including our Estimate Your Cost tool, which lets members compare how much different local doctors and hospitals charge for 40 specific medical procedures, like MRIs and pregnancy delivery, as well as performance and safety ratings
- SpecialOffers@Anthem℠ — Discounts on health-related products and services, such as smoking cessation programs, fitness club memberships and much more
- AudioHealth Library — Access to more than 400 health topics by phone

Other resources and tools include online preventive guidelines, health newsletters and more.

Health guidance

- 24/7 NurseLine — Anytime, 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.
- Future Moms — A program that offers moms-to-be coaching, education and support throughout their pregnancy, with nurse coaches who can answer pregnancy-related questions 24 hours a day

Other health guidance programs include preventive care reminders, comprehensive health management and more.

Health management and coordination

- ConditionCare — For members trying to manage chronic conditions, such as asthma, diabetes, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD) and heart failure, ConditionCare helps them 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. This program is included in all fully insured member plans, except those with a consumer-driven health plan component.
- Case Management — Provides one-on-one expert nurse coaching to help members find and receive the right services if they have a complicated medical situation or a recent significant hospitalization.

Healthy support

In addition to the clinical programs listed above, we offer Healthy Support plans that cover fitness reimbursement and other incentives to award a healthy lifestyle.

BlueCard®

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 Shield health plan). BlueCard offers access — at significant savings — to doctors and hospitals outside Colorado that participate in other Blue Cross and Blue Shield plan networks. The program features help with locating participating providers from a roster that includes more than 70% of doctors and 80% of hospitals in America. In addition to cost savings, BlueCard offers the security of access to quality health care, wherever our PPO members travel in the United States.

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

Forms and supplies

Downloading, requesting and ordering forms

Go online — View and print forms from our website at www.anthem.com

Life insurance

Offered by Anthem Life Insurance Company

This section is applicable only if life insurance is included in your group's benefits package.

Premiums

Premiums for life insurance are billed on a monthly basis and are combined with your group's other benefit premiums in one consolidated bill (see the **About your billing** section). Premiums must be paid on or before the due date and should be sent with the payment coupon to the address below:

Anthem Blue Cross and Blue Shield
P.O. Box 51011
Los Angeles, CA 90051-5311

Do not adjust your bill to reflect membership changes. All eligibility changes should be made on the *Employee Application* or on company letterhead signed by a group official or authorized group contact. The changes will be reflected with any necessary adjustments on the next month's bill.

Enrolling new employees

An *Employee Application* must be submitted to enroll a new employee in life insurance. See **Coverage effective dates** in the **Enrollment guidelines** section for information about when we must receive applications. Applicants who apply for coverage and submit their complete, signed enrollment forms within 45 days of their eligibility date will be added as of the original effective date. However, if we receive forms after the 45-day eligibility period expires, the applicants are considered late enrollees and the following applies:

- In **contributory** groups (both the employer and the employees contribute to the monthly premium cost), the applicant must then satisfy medical evidence underwriting; the applicant will be enrolled effective the first of the month following the approval date.
- In **noncontributory** groups (the employer pays 100% of the monthly premium cost), the applicant's enrollment will be effective on the same date as the employee's original eligibility date, and the employer will be responsible for any premium amounts due during the interim.

Changing coverage

The employer is responsible for notifying Anthem about any change in an employee's status that would result in a change in coverage levels. For example, if your group offers more than one level of life insurance and an employee experiences a change in job classification, salary or any other event that would cause an increase or decrease in benefits, you must inform Anthem immediately by submitting a letter of request. Changes related to increase in life insurance amounts are done annually at the group's anniversary and would impact any and all changes for the entire group that may qualify.

Ending coverage

The employer is responsible for notifying Anthem about a requested coverage cancellation due to employment termination or other reasons, including death of the employee. Provide the notice by completing an *Employee Application* or send the request in writing with the signature of a company official or authorized group contact and fax it to **1-855-750-2227 or email to small.group@anthem.com.**

Salary-based plans

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

Beneficiary designations

Designation of a beneficiary is required for life insurance coverage. The name of the employee's designated beneficiary must be indicated on the appropriate form and in a manner approved by Anthem Life Insurance Company. The employee can change the beneficiary at any time. Any life insurance benefit payment made by Anthem Life Insurance Company under the policy and before we receive such notice willfully discharges our obligation for payment.

If the beneficiary designation is unclear at the time a claim is filed, a beneficiary will be assigned according to state law.

Actions and forms

You can view or print forms from our website at www.anthem.com. You may also request that forms be faxed or mailed to you by calling Customer Service at **1-800-922-4770**.

Desired action	Form to use	Notes	Mail to
Change employee's name or beneficiary designation	*Employee Enrollment Supplemental Application: Section 3*	The change won't be effective until we receive the form. The employer is responsible for keeping a copy of the beneficiary form on file as well.	Anthem Life Insurance Company Small Group Services P.O. Box 172405 Denver, CO 80217
Request life insurance conversion information	ADM Not/ Conv 9708 *Notice of Conversion Privilege for Group Life Insurance*	The employer must provide the completed form to each terminated employee within 31 days of the date the employee becomes ineligible for group life/AD&D insurance due to termination of employment, retirement or any other reason. The employer is responsible for notifying employees about their right to convert life benefits.	Provide the form to the terminated employee, who then must complete and sign the form if he or she wants conversion coverage. The employee then must mail the completed form to: Anthem Life Insurance Company P.O. Box 182361 Columbus, OH 43218-2361
Claim death benefits	*Beneficiary Claim Form* AL-2114 (4/08)	The employer is responsible for submitting a life claim upon the death of an insured employee.	Anthem Life Insurance Company Ohio Claims Center P.O. Box 182361 Columbus, OH 43218-2361

Waiver of premiums

- If an employee becomes completely disabled before age 60 and remains totally and continuously disabled, Anthem Life Insurance Company will pay the insured employee's beneficiary the applicable life insurance amount, upon the death of the insured, according to the schedule of benefits.
- The claim amount cannot exceed the amount of the insurance in force at the time the total disability began.
- To initiate this benefit, Anthem Life Insurance Company must be notified within 12 months from the date of the disability.
- If the disability has been continuous for at least nine months (and no more than 12 months has passed from the date of total disability), a *Total Disability Claim Form* must be completed:
  - The employer must complete the policyholder section of the form and the employee must complete the insured section.
  - We must receive the form within 12 months of the last day the employee worked due to the disability.
- If a death occurs during the period of total disability, a claim must be submitted, whether or not the initial notification of disability was made.

Dental Prime and Dental Complete coverage

By offering dental coverage to your employees, you add value to their benefits package.

Integration: Members who are pregnant or living with diabetes can receive one additional dental cleaning or periodontal checkup each year.

Network: Access to more than 100,000 dentists and specialists nationwide. We offer different sizes of networks that allow your employees to control costs without reducing benefits.

Additional Features: Our plans include these unique member features:

- One hundred percent in-network preventive care to keep employees healthier and more productive.
- More discounts beyond annual maximum.
- Wide range of annual maximum options including annual maximum carryover.
- Variety of plan designs.
- Orthodontia options available for group with 5+ enrolling subscribers.
- A benefit for brush biopsy to help diagnose cancer in time for treatment.

Service: With more than 40 years of dental administration experience, the consistency of our U. S.-based customer service operations exceeds service standards.

Participation requirements

- Employer-paid dental plans for groups 2 to 100:
  - Classic, Value and Enhanced – Groups with 2 to 4 employees require 100% participation. For groups with five or more eligible employees, a minimum of two employees must enroll, with a minimum of 60% of the net eligible employees.
  - A minimum of 15 eligible employees must be enrolled to select a dual option. At least five employees must be enrolled in each option.
- Voluntary dental plans for groups 5 to 100:
  - A minimum of five employees must enroll in the stand-alone dental products. No further participation is needed.
  - A minimum of 15 eligible employees must be enrolled to select a dual option. At least five employees must be enrolled in each option.

A year-by-year look at the health care reform law

2010

As of March 23

- Early Retiree Reinsurance Program, operational as of June 29, 2010
- Temporary high-risk pool for individuals with pre-existing conditions, operational as of July 1, 2010
- Small group tax credit, effective for tax years beginning after December 31, 2009

Implemented on the next plan year for all plans (grandfathered or not) on or after September 23, 2010

- Dependent coverage for adult children up to age 26 (In some states, dependents can stay on the plan even longer)
- No lifetime coverage limits
- 100% coverage for preventive services in network*
- No annual limits on certain types of benefits
- No prior authorization for emergency services or higher cost sharing for out-of-network emergency services*
- No pre-existing condition exclusions for children
- Nondiscrimination in favor of highly compensated employees*

2011

- No pretax reimbursements from health account for nonprescribed, over-the-counter medications
- 20% tax for nonqualified HSA withdrawals
- Reporting the value of employer-sponsored coverage on W-2s
- Automatic enrollment in new long-term care program, with ability for employees to opt out
- Small employer grants for wellness programs for fiscal year 2011, so technically starts October 1, 2010

2012

- Uniform explanation of coverage
- Pre-enrollment document sent explaining benefits and exclusions
- 60-day notice for material modifications, if not provided in uniform explanation of coverage

2013

- Employee notification of exchanges, premium subsidies and free choice vouchers
- Fee for comparative effectiveness research agency for fiscal year 2013, which technically begins October 1, 2012
- FSA contributions limited to $2,500 per year

2014

- Individual mandate
- State-based exchanges for individuals and small groups
- Small employer tax credits available only in exchange
- Free choice voucher required to be provided to qualifying employees
- Elimination of health status rating and other rating factors if used by an insurer*
- Small group redefined as 1-100 (in most states)
- Employer requirement to offer minimum essential coverage (50+ employees)
- HIPAA nondiscrimination rules on wellness programs
- 30% incentive cap for wellness programs
- New fee on fully insured coverage
- 90-day limit on waiting periods for coverage

2018

- 40% excise tax on high-cost “Cadillac” plans

* The law does not require grandfathered plans to comply with this provision.

For more information, please visit anthem.com/healthcarereform or healthcare.gov.

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

Notes

Notes

Thank you for choosing Anthem

We want to thank you, again, for giving your employees valuable health care coverage and for trusting us to give you all of the choices and services your business needs. If you ever have any questions, please feel free to call us at 1-877-833-5734. We appreciate the opportunity to improve the lives of the people we serve and the health of our communities.

www.anthem.com

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