Anthem®

Health · Pharmacy · Dental · Vision · Life · Disability

1-100 Small Group Underwriting guidelines

Designed for agents and producers

Effective January 2019

45277CABENABC Rev. 09/18

Important contact information

Small Group Underwriting address
Anthem
P.O. Box 9042
Oxnard, CA 93031-9042

Small Group Underwriting
New business: newsguwca@anthem.com
Existing business: sguwca@anthem.com
New business telephone: 1-855-239-9251

For overnight delivery only
Anthem
Small Group Underwriting
4553 La Tienda Drive
Thousand Oaks, CA 91362

Small Group Customer Service
Telephone: 1-855-854-1429
Email: small.group@anthem.com
Hours: 8 a.m. to 6 p.m. PT (Monday–Friday)

Broker Services
Telephone: 1-800-678-4466
Email: agent.support@anthem.com
Hours: 8:30 a.m. to 5 p.m. PT (Monday–Thursday)
8:30 a.m. to 3 p.m. PT on Friday

Rapid Quote
Telephone: 1-877-275-3700
Email: rapidquote@anthem.com

Anthem website: https://www.anthem.com/ca/

Making Health Care Reform Work website:
makinghealthcarereformwork.com

Quoting tool: https://brokerportal.anthem.com/ehb/web/bkr/acc/login.htm

Dental, vision, life and disability quoting

- Anthem Connect Team (2-25 lives):
  connect@anthem.com
- 26-100 lives:
  anthemspecialtyquotes@anthem.com

For *Agents & Producers* section of website

My user ID: _____

My password: _____

To order supplies
Fax: 1-877-255-4015
(fax completed *Agent Supply Request* form only)

Online: https://brokerportal.anthem.com/ehb/web/bkr/acc/login.htm?wlp-brand=anthem

View these guidelines and other documents online
Go to https://www.anthem.com/ca/ and select **Producers**. Then, log in and select **Sales and Training**. From there, you can view, download and print forms and documents.

Anthem Connect Team
Telephone: 1-877-567-1802
Hours: 5 a.m. to 5 p.m. PT (Monday-Friday)
Email: connect@anthem.com
Mail: Anthem Connect
730 S. Broadway
Gilbert, MN 55741

***Summary of Benefits and Coverage* (SBC) links**

- 2014 2018 Affordable Care Act-compliant plans:
  sbc.anthem.com
- Producer Toolbox:
  https://brokerportal.anthem.com/ehb/group/bkr/stl/product-information

Census enrollment: https://brokerportal.anthem.com/ehb/web/bkr/acc/login.htm

Easy renew: https://www11.anthem.com/easyrenewsite/home.html

Producer news: news.anthem.com/ca

Standard Industry Classification (SIC) codes

- listsareus.com/business-sic-codes.htm#codes
- osha.gov/pls/imis/sicsearch.html

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Thank you for choosing Anthem

At Anthem Blue Cross (Anthem), our goal is to provide you with clear guidance so you can help your clients choose the best health care options.

We want to help you grow your book of business, increase client retention and create an easy-to-do-business-with environment.

Remember, agents are not authorized to bind or guarantee issue coverage. Anthem will make the final decision to accept or decline a case. Please advise your prospective clients to maintain their current coverage until we notify them in writing that Anthem has approved their coverage.

While Anthem is committed to keep all parties informed of any changes to these Small Group Underwriting guidelines in a timely manner, Anthem may change these guidelines at any time without prior notice.

The information contained in these guidelines is intended for use by authorized agents only and should ***not*** *be copied or distributed for any other purpose.*

Overview of the underwriting process

What to submit (employer level)

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

- A copy of agent's quote (based on final enrollment)
- The most current *Employer Enrollment Application/ Fillable Application* including the COBRA/FMLA/ Cal-COBRA questionnaire; the last billing statement listing COBRA/Cal-COBRA subscribers, if applicable
- A copy of the company's most recent *Quarterly State Tax Withholding Report* with the current employment status of all employees listed* (payroll may be required)
  - 1st quarter due with state by 4/30
  - 2nd quarter due with state by 7/31
  - 3rd quarter due with state by 10/31
  - 4th quarter due with state by 1/31
- If "takeover" coverage, a copy of the prior carrier's last month's group billing for all lines of coverage with status of all listed employees
- A completed *Electronic Debit Payment* form for 100% of the first month's premium made payable to Anthem (If electronic debit is not agreed to, a company check may be accepted, subject to additional processing time.)
- Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect Social Security numbers

Employee enrollment

- Each eligible employee/owner must complete an application or waiver.
- Agents must keep a copy of the employee application or waiver.

Group enrollment solutions

Groups enroll in one of our employee enrollment solutions tools.

- EaseCentral
- Salesforce
- Online Census Enrollment tool
- Online Member Enrollment

To access the Census Enrollment tool, go to https://brokerportal.anthem.com/ehb/web/bkr/acc/login.htm. After logging in, select the **Sales and Training** tab. From there, select the **Small Group Business Customer Forms** tab. Then, select **Excel Census Tool**.

Completing forms

Please ensure all questions are answered and signatures and dates obtained. Please confirm the following before submitting:

- No alterations to preprinted materials will be accepted.
  - Only the employer may fill in, change or modify the *Employer Application*.
  - Only the employee may fill in, change or modify the *Employee Application*.
- Whenever an individual has a language barrier and requires assistance to properly complete the application, the application must be submitted with a signed Anthem *Statement of Accountability/Translator Statement* from the group or the agent.

* See section 3,"California underwriting business requirements," for sole proprietors, partners or corporate officers not appearing on the *Quarterly State Tax Withholding Report*.

Overview of the underwriting process

Submission timeline

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

- Anthem will accept new group submissions for the following effective dates:
  - First of the month — by the 5th working day of the month
  - 15th of the month — by the 12th calendar day of the month
- If Anthem requests any additional information prior to making a new group determination, it should be received within 10 days of the original request.
- If the information submitted is incomplete and subsequently not received in a timely manner, the group's application may be withdrawn for the month requested.
- It is the agent's responsibility to notify the Underwriting department prior to approval if a change in the requested effective date is to be considered. A request for change will be required in writing from the employer.

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

New group submission criteria

Underwriting is based on the following criteria:

- Employee and dependent eligibility
- Employer contribution
- Employee participation
- Evidence of insurability will be required for life benefit amounts over guaranteed amount. Evidence of insurability is also required for late entrants.
- Long-term disability for groups of 2-5 eligible employees is medically underwritten. Evidence of insurability is required.

General underwriting guidelines for Small Group business

Group eligibility requirements

Any group qualifying as a small employer and meeting the following eligibility requirements is eligible for Anthem's Small Group health plans on a guaranteed issue and guaranteed renewability basis. To qualify for Anthem coverage, a group must meet the following criteria:

- For plan years commencing on or after January 1, 2016, a small employer is defined as an employer employing an average of at least one, but no more than 100 full-time, including full-time equivalent, employees during the preceding calendar year and who employs at least one employee on the first day of the plan year. For purposes of determining employer eligibility in the small employer market, California adopted the federal method for counting full-time employees and full-time equivalent employees. (SB 125, 2015).
- Group must be a person, firm, proprietary or nonprofit corporation, partnership, public agency or Guaranteed Association. The employer must be actively engaged in business or service.
- Group must have and maintain business licensure and/or appropriate state filings allowing the company to conduct business in California.
- Group must not have been formed primarily for the purpose of obtaining health insurance.
- Group must involve a bona fide employer-employee relationship.
- An individual who wholly owns the company on his/her own or with his/her spouse/domestic partner, the spouses of sole proprietors, partners of a partnership and their spouses, a 2% S corporation shareholder, a worker described in Section 3508 of Title 26, Internal Revenue Code, or a leased employee (as defined in 26 U.S.C. § 414(n)(2)) does not qualify as an employee for purposes of group eligibility.

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

  Affiliated companies — Companies that are affiliated and eligible to file a combined tax return for purposes of state taxation shall be considered one employer.

  The following are examples of groups that are not considered small employers:

  - Owners on their own or with their spouses/domestic partners, officers or partners
  - Carve-out groups
  - Employer groups with less than 51% of employees working in California

  Note: Groups wanting to re-apply for Anthem coverage must be in good standing and pay any premium balance due.

Employee eligibility requirements

- Permanent employees who are actively engaged on a full-time basis in the conduct of the business of the small employer, with a normal work week of an average of 30 hours per week over the course of a month, at the small employer's regular place of business, who have met any statutorily authorized applicable waiting-period requirements.
- Sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis (average of 30 hours per week over the course of a month) in the employer's small business and included as employees under a health care service plan contract of a small employer.
- Permanent employees who work at least 20 hours, but not more than 29 hours, are deemed to be eligible employees if all four of the following apply:
  - The employee otherwise meets the definition of an eligible employee except for the number of hours worked.
  - The employer offers the employees health coverage under a health benefit plan.
  - All similarly situated individuals are offered coverage under the health benefit plan.
  - The employee worked at least 20 hours per normal workweek for at least 50% of the weeks in the previous calendar quarter. The health care service plan may request any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.
  - Please see page 8 for additional life and disability guidelines.
- Seasonal, temporary or substitute employees, defined as employees hired with a planned future termination date, are not eligible. Employees compensated on a 1099 basis are not eligible. Sole proprietors, spouses of sole proprietors, partners of a partnership and the spouses of those partners are not considered employees.
- Employees must reside within the 48 contiguous states, Alaska, Puerto Rico or United States Virgin Islands.

General underwriting guidelines for Small Group business

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

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

If the employee is rehired more than 91 days (13 weeks) after the termination date, the employee is considered a new employee, subject to applicable group-imposed waiting periods and must complete a new *Employee Enrollment Application*. The group is responsible for notifying us immediately if an employee is rehired and will be continuing coverage.

Residents of Hawaii

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

Contribution

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

Medical

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

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

Dental

For voluntary plans, employers may contribute between 0% and 49%.

Vision

- Employer-sponsored plans require employer to contribute between 50% and 100%.
- For voluntary plans, employers may contribute between 0% and 49%.

Life

- Basic life: Minimum employer contribution (not including dependent coverage) is 25% for contributory plans and 100% for noncontributory plans. Payroll deduction is required, if contributory.
- Optional life: 100% employee-paid. Payroll deduction is required.
- Voluntary life: 100% employee-paid. Payroll deduction is required.

Disability

- Short-term disability: Minimum employer contribution (not including dependent coverage) is 25% for contributory plans and 100% for noncontributory plans. Payroll deduction is required, if contributory.
- Voluntary short-term disability: 100% employee-paid. Payroll deduction is required.
- Long-term disability: Minimum employer contribution (not including dependent coverage) is 25% for contributory plans and 100% for noncontributory plans. Payroll deduction is required, if contributory.
- Voluntary long-term disability: 100% employee-paid. Payroll deduction is required.

Medical plan participation

The group participation requirements are:

- 70% — groups with 1-14 eligible employees
- 50% — groups with 15 or more eligible employees
- Minimum participation is 100%, if noncontributory

Anthem may conduct periodic audits to confirm participation levels.

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

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

For purposes of calculating participation, the following are considered valid waivers, subject to receipt of a declination and proof of other coverage, such as:

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

Note: An owner of multiple entities will not be considered a valid waiver if the owner is declining due to coverage under another entity in which he/she holds ownership. Dual coverage by the same employer would not be considered a valid waiver.

Medical plan names

- **Anthem Platinum** — These provide the highest level of benefits, and employees often pay less when they get care. However, these plans have the highest monthly premiums.
- **Anthem Gold** — These provide richer benefits than the Silver and Bronze plans, and employees pay less when they get care. However, the monthly premium is higher than with those plans.
- **Anthem Silver** — These offer affordable monthly premiums, but compared to the Bronze plans, employees pay less when they get care**.**
- **Anthem Bronze** — These feature broad benefits and the lowest monthly premiums, but employees pay more when they get care; deductibles, copays and cost shares may be higher than with the other plans.

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

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

Product types

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

Network options

PPO

- **Prudent Buyer PPO network** — Access to nearly 60,000 California doctors and specialists, and more than 330 hospitals
- **Select PPO network** — Access to more than 40,000 California doctors and specialists, and more than 300 hospitals

Note: Employers may choose only one PPO network.

HMO

- **CaliforniaCare HMO network** — Access to more than 42,000 California doctors and specialists, and more than 330 hospitals
- **Select HMO network** — Access to more than 26,000 California doctors and specialists, and nearly 250 hospitals

General underwriting guidelines for Small Group business

Note: Employers may choose only one HMO network.

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

Dental coverage

Small Groups with 2-100 employees may choose one Dental Net DHMO plan and one Essential Choice PPO plan.

Dental Net DHMO

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

- 2-4 eligible employees: 65% of eligible employees (and a minimum of two employees enrolled) not covered under another dental plan are required to enroll.
- 5-100 eligible employees: A minimum of 25% net eligible employees must enroll with a minimum of two.
- Minimum participation is 100%, if noncontributory.
- Dual option (employer can select two plans to offer to employees) is available for groups with at least 10 net eligible employees. A minimum of two employees must enroll in each of the two options and the two plans offered must have a 10% premium differential.
- Orthodontic coverage for adults and children is included in all Dental Net DHMO plans.
- Waiting periods are not required for Dental Net DHMO plans (including plans with optional dental implant coverage).

Note: Dental Net DHMO office numbers are required.

Essential Choice PPO Classic and Enhanced

- 2–4 eligible employees: 65% of eligible employees not covered by another dental plan (and a minimum of two employees) are required to enroll.
- 5–100 eligible employees: A minimum of 25% of net eligible employees of employees not covered by another dental plan are required to enroll. A minimum of two employees must enroll.
- Dual option (employer can select two plans to offer to employees) is available for groups with at least 10 net eligible employees. A minimum of two employees must enroll in each of the two options and the two plans offered must have a 10% premium differential.

Voluntary dental plans

Available for groups of 5-100 eligible employees:

- A minimum of five employees must enroll (there is no participation percentage requirement for our voluntary plans). Voluntary rating status is defined as any participation percentage less than 60%.
- Dual option (employer can select two plans to offer to employees) is available, with a minimum of five employees required to enroll in each plan. You may choose one Voluntary Dental Net DHMO plan and one Voluntary Essential Choice PPO plan. There must be a 10% differential in the premiums rates based on the single plan.

Note: Group must be headquartered in California. Seasonal or temporary employees are not eligible. Dental offices/clinics are not eligible.

Pediatric dental

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

Vision coverage

Anthem now offers Blue View Vision℠.

Employer sponsored

- Available for 2-100 employees.
- A minimum of two employees must enroll.
- Minimum participation is 50% of total eligible employees, if noncontributory.
- Dual option is available (employer can select two plans to offer to employees). Employer may choose a maximum of two plans, but may not pair a voluntary plan with an employer-sponsored plan. Dual option requires at least 10 eligible employees. Two or more employees must enroll in each option.

Voluntary vision

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

Pediatric vision

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

Adult exam-only

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

Life coverage

These are the general guidelines we use when evaluating groups. Life and disability underwriting guidelines differ from medical underwriting guidelines. This is not a complete list of all life and disability underwriting requirements. Each group is evaluated during the underwriting process. These basic underwriting guidelines are subject to change at a life underwriter's discretion.

These underwriting guidelines apply to all life and disability products. Additional guidelines for each product are shown below:

- Availability: Group must have at least two eligible employees for basic life, short-term and long-term disability. Group must have the greater of 20% participation or 5 eligible employees enroll for optional supplemental life or optional voluntary life. Group must have the greater of 20% participation of 10 eligible employees enroll for voluntary short-term disability or voluntary long-term disability.
- 24-month rate guarantee.
- Valid and appropriate SIC must be used for quoting. See the ineligible industries list for the SIC codes that are not eligible. Rates are subject to change if appropriate SIC is not used.
- Group must be in good financial status. Groups in bankruptcy are not eligible.
- Group must have been in business at least one year for short-term disability, long-term disability, voluntary short-term disability and voluntary long-term disability.
- Employees must be actively at work. Employees must be U.S. citizens working in the U.S. or approved foreign nationals with U.S. work visas working in the U.S.
- Retiree coverage is not available.
- 1099 workers/contractors are not eligible for coverage.
- May be sold with other Anthem and its affiliates' products or as stand-alone.
- Employees must work at least 30 hours per week to be eligible.
- Groups must maintain the minimum participation levels to remain eligible. Groups may not be renewed if participation falls below the required minimum.

Basic life

- Benefit options:

Group size 2-9	Group size 10-100
Flat-amount benefit options of $15,000, $25,000 $30,000, $50,000	Flat benefit amount from $15,000 to $500,000 in $1,000 increments ($10,000 benefit available for groups that also offer optional life)
Salary-based benefit option of 1x annual earnings	Salary-based benefit options of 1x, 2x, 3x, 4x or 5x annual earnings
Guaranteed issue is $50,000	Guaranteed issue amount varies by group

Census must be submitted for quoting. Census must include:

  - Gender.
  - Age or date of birth.
  - Class designation (if benefits vary by class).
  - Salary (if benefits are salary based) .
  - Name or employee ID.

- Groups of 2-9, age-banded rates. Groups of 10+, composite rates.
- Participation requirements:
  - All eligible employees must participate when coverage is entirely employer paid. (Religious waiver allowed with written documentation.)
  - 75% of eligible employees must participate when employee contribution is required.

General underwriting guidelines for Small Group business

These participation requirements are the same for basic life sold with or without medical and for basic life sold with or without other life and disability products.

- Contribution requirements: Minimum employer contribution (not including dependent coverage) is 25% for contributory plans and 100% for noncontributory plans.
- Benefit may vary by class based on employer offering by class up to maximum number of classes: 2-9, one class; 10+, five classes. No more than 2.5x difference in life benefit amount between classes. It is acceptable to create a class with a $50,000 maximum benefit for those employees desiring no imputed income for tax purposes.

No open enrollment allowed. Annual enrollments are allowed for contributory coverage; late enrollees are subject to evidence of insurability.

Basic dependent life

- Benefit options:

Group size 2-9	Group size 10-100
$10,000 spouse/$5,000 each child	$20,000 spouse/$10,000 each child
$5,000 spouse/$2,500 each child	$15,000 spouse/$7,500 each child
	$10,000 spouse/$5,000 each child
	$5,000 spouse/$2,500 each child
	$2,000 spouse/$1,000 each child

- Dependent coverage cannot exceed 50% of the employee amount.
- Child coverage begins on 15th day following birth/ends at age 26.
- Family unit rate structure.
- All dependent life amounts are guaranteed issue.

Optional supplemental life/optional voluntary life

- Benefit options:

Group size 10-100
Flat amounts from $10,000 to $500,000 in $5,000 increments
1x, 2x, 3x , 4x or 5x annual earnings

- Census must be submitted for quoting. Census must include:
  - Gender.
  - Age or date of birth.
  - Class designation (if benefits vary by class).
  - Salary (if benefits are salary-based).
  - Elected coverage amounts.
  - Name or employee ID.
- Age-banded rates.
- Optional supplemental life must be sold with basic life. Optional voluntary life is sold as stand-alone.
- Participation requirement: Greater of 20% of eligible employees or five employees must enroll. Example: A group with 10 employees will need to have five employees enroll to satisfy the 'greater of' requirement.
- Contribution requirement: 100% employee-paid.
- Optional supplemental life only — employees must be enrolled in basic life coverage.
- Initial open enrollment is included for 30 days from group effective date. For groups with optional/voluntary life benefit of more than $100,000, the initial open enrollment guaranteed Issue limit is $100,000.
- Takeover coverage: Standard one-time open enrollment is included for 30 days from group effective date for takeover coverage on groups with 10 or more eligible lives.
  - For groups with optional/voluntary life employee guaranteed issue limit of more than $100,000, the initial open enrollment employee guaranteed issue limit is $100,000. For example, if the group's employee guaranteed issue limit is $200,000, the initial open enrollment employee guaranteed issue limit is $100,000.
  - For groups with optional/voluntary life employee guaranteed issue limit of less than $100,000, the initial open enrollment employee guaranteed issue limit is the group's employee guaranteed issue limit. For example, if the group's employee guaranteed issue limit is $50,000, the initial open enrollment employee guaranteed issue limit is $50,000.
  - For groups with optional/voluntary life spouse guaranteed issue limit of more than $10,000, the initial open enrollment spouse guaranteed issue limit is $10,000. For example, if the group's spouse guaranteed issue limit is $20,000, the initial open enrollment spouse guaranteed issue limit is $10,000.

- For groups with optional/voluntary life spouse guaranteed issue limit of less than $10,000, the initial open enrollment spouse guaranteed issue limit is the group's spouse guaranteed issue limit. For example, if the group's spouse guaranteed issue limit is $5,000, the initial open enrollment spouse guaranteed issue limit is $5,000.
- This is not an annual open enrollment.
- Future enrollments require evidence of insurability for late enrollees and increases in coverage regardless of amount.
- Requests for takeover/grandfathering of optional/voluntary life amounts must be reviewed and approved by Life & Disability Underwriting.

- New coverage: Initial open enrollment is included for 30 days prior to group effective date for groups that have never offered optional supplemental/voluntary life. Employees and dependents may enroll up to the guaranteed issue limits without evidence of insurability.
- No annual open enrollment. Evidence of insurability is required for late enrollees and increases in coverage regardless of amount.
- Evidence of insurability is required for all coverage amounts above guaranteed issue limits.

Optional supplemental/optional voluntary dependent life

- Benefit options:

Spouse – flat benefit available from $10,000 to $50,000 in $5,000 increments
Child – $5,000, $10,000, $15,000; cannot exceed 50% of spouse amount

- Dependent coverage cannot exceed 50% of the employee amount.
- Child coverage begins on 15th day following birth/ends at age 26.
- Family unit rate structure.

Disability coverage

Short-term disability and long-term disability

- Benefit options:

Group size 2-9	Group size 10-100
Short-term disability – Flat amount $250 per week – 60% of weekly earnings	Short-term disability – Flat amount of $100, $150, $200 or $250
– 67% of weekly earnings (must be noncontributory)	– 40% of weekly earnings – 50% of weekly earnings – 55% of weekly earnings – 60% of weekly earnings – 67% of weekly earnings (must be noncontributory) – 70% of weekly earnings (must be noncontributory)
Long-term disability – 60% of monthly earnings	Long-term disability – 40% of monthly earnings – 50% of monthly earnings – 60% of monthly earnings – 67% of monthly earnings (must be noncontributory)

- Census must be submitted for quoting. Census must include:
  - Gender.
  - Age or date of birth.
  - Class designation (if benefits vary by class).
  - Salary.
  - Occupations (for long-term disability).
  - Elected coverage amount
  - Name or employee ID.
- Groups of 2-9, age-banded rates. Groups of 10+, composite rates.
- Participation requirements:
  - All eligible employees must participate when coverage is entirely employer-paid. (Religious waiver allowed with written documentation.)
  - 75% of eligible employees must participate when employee contribution is required.
- Short-term and long-term disability are available independent of each other.
- Contribution requirements: The minimum employer contribution for short-term disability insurance coverage is 25% for contributory plans and 100% for noncontributory plans.

General underwriting guidelines for Small Group business

- No open enrollment allowed. Timely enrollment is required for new employees. Employees hired after the effective date of the plan will become eligible for insurance after completing the waiting period specified in the policy.
- Short-term disability does not replace the state-mandated benefits of CA, NY, NJ, HI, PR or RI. This plan will integrate or offset with the state-mandated coverage where employees covered by such plans exist at time of claim. If the census data provided for a quote includes state location at the employee level, the state-mandated plan benefits will be considered in setting our pricing.
- Pre-existing condition limitation applies to long-term disability.

Voluntary short-term and long-term disability

- Benefit options:

Groups of 10-100
Voluntary short-term disability
– Flat amount of $100, $200 or $250 per week
– 50% of weekly earnings
– 55% of weekly earnings
– 60% of weekly earnings
Long-term disability
– 50% of monthly earnings
– 60% of monthly earnings

- Census must be submitted for quoting. Census must include:
  - Gender.
  - Age or date of birth.
  - Class designation (if benefits vary by class).
  - Occupations (for voluntary long-term disability)
  - Elected coverage amount.
  - Name or employee ID.
- Age-banded rates.
- Participation requirement: Greater of 20% of eligible employees or 10 employees must enroll.
- Voluntary short-term and voluntary long-term disability are available independent of each other.
- Contribution requirements: no employer contribution.
- Takeover coverage: No standard one-time open enrollment for takeover coverage. Evidence of insurability is required for late enrollees and increases in coverage regardless of amount.
- New coverage: Initial open enrollment is included for 30 days prior to group effective date for groups that have never offered voluntary short-term and long-term disability. Employees may enroll up to the guaranteed issue limits without evidence of insurability.
- No annual open enrollment. Evidence of insurability is required for late enrollees and increases in coverage regardless of amount.
- Evidence of insurability is required for all coverage amounts above guaranteed issue limits.
- Pre-existing condition limitation applies to voluntary short-term and voluntary long-term disability.
- Quote for voluntary long-term disability assumes participation in Social Security. Groups that do not participate in Social Security or have other state or local disability plans must be quoted by life & disability Underwriting.

This information is intended to be a brief outline of life and disability underwriting guidelines and not intended to be a complete description of the underwriting policies. Each group is underwritten individually and other underwriting factors apply. Anthem and its affiliates may decline to quote on a group. Groups in certain SIC classifications are not eligible for coverage. In the event of a conflict between a proposal and this document, the terms of the proposal will prevail.

Premium only plan (POP)

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

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

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

Establishing a POP arrangement through WageWorks, Inc. is convenient.[1] The cost of a POP is only $125 per year. Groups with 10 or more eligible employees on medical and life plans will receive the first year's POP services from WageWorks at no charge. Submit a separate check for the POP premium, made payable to Anthem, along with the POP application.

For more information about POP, contact WageWorks at 1-800-876-7548 (8 a.m. to 5 p.m. CT) or go to **ezpop.com**. For tax advice, consult your tax advisor.

For complete details, order the *Employer's Guide to the Premium Only Plan* available online at anthem.com/easyrenew.

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

Rating policies

- All rates will be based on actual enrollment.
- For Small Group plans, the rate for the family is based on the combined ages of the employee, spouse, all dependents 21 and older, and up to the three oldest dependents 20 or younger. The premium is determined by the employer's principal business ZIP code.[1]
- Dental, vision and life products require SIC code to determine rate.
- Dental and vision require the number of eligible employees to determine rate.
- Medicare primary and secondary rates are the same.

Rate and benefit guarantee

- Medical rates are guaranteed for a minimum of 12 months. The anniversary month will determine the timing of future adjustments.
- Stand-alone dental has a 12-month rate guarantee.
- Life rates are guaranteed for 24 months.
- Dental and vision require the number of eligible employees to determine rate.
- Vision rates and benefits are guaranteed for 24 months.
- Rates will adjust for age at contract anniversary.

Waiting periods

Pursuant to SB 1034 (2014), Anthem will not impose a waiting period. Groups are responsible for providing Anthem with accurate member eligibility dates, taking into account any group-imposed waiting period. In accordance with SB 1034, groups are responsible for ensuring that any group-imposed waiting period is consistent with Section 2708 of the Federal Public Health Service Act (42 U.S.C. Sec. 300gg-7).

Waiting period options are as follows:

- First of the month following date of hire
- First of the month following one month from date of hire
- First of the month following two months from the date of hire, not to exceed 90 days[2]

The employer has the option to waive the waiting period for all new hires at the initial group enrollment only.

The group's waiting period is applied to all employees in the group with no exceptions for any eligible employee.

Note: Dual waiting periods are not allowed. Does not apply to life and disability coverage.

Takeover provisions

Small Group takeover provisions comply with the following:

- Any carrier providing replacement coverage with respect to hospital, medical or surgical expense, or service benefits within a period of 60 days from the date of discontinuance of a prior contract or policy providing such hospital, medical or surgical expense or service, benefits will immediately cover all employees and dependents who were validly covered under the previous contract or policy providing such hospital, medical or surgical expense, or service benefits at the date of discontinuance and are within the definitions of eligibility under the succeeding carrier's contract and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active full-time employment or hospital confinement or pregnancy.
- However, with respect to employees or dependents who are totally disabled on the date of discontinuance of the prior carrier's contract or policy and entitled to an extension of benefits pursuant to subdivision (b) of Section 1399.62, or pursuant to subdivision (d) of Section 10128.2 of the Insurance Code, the succeeding

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

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

carrier is not required to provide benefits for services or expenses directly related to any conditions that caused the total disability.

Prior deductible credit/annual maximum copay/dental benefit waiting period credit

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

Dependent eligibility

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

- Lawful spouse
- Registered domestic partner (Family code Section 297)
- Disabled dependent child, who at the time of becoming age 26, is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition, and is chiefly dependent on the subscriber for support and maintenance (A disabled dependent may be eligible for benefits beyond his or her 26th birthday. The employee will be required to submit physician certification of the child's condition.)
- An employee's, spouse's or registered domestic partner's child under age 26:
  - Natural child
  - Newborn child
  - Stepchild
  - Legally adopted child
  - Ward of legal guardian
  - Child for whom the eligible employee has assumed a parent-child relationship (does not include foster children), as indicated by intentional assumption of parental status or assumption of parental duties by the eligible employee (The employee for the annuitant must certify at the time of enrollment of the child and annually thereafter.)

Note: In the case of birth, adoption or placement for adoption, the child will be covered for the first 31 days from the date of birth, adoption or placement for adoption. To continue the plan beyond the 31 days, Anthem must receive an application for coverage of a dependent child within 60 days of the child's eligibility. Coverage will be effective beginning on the date of birth or adoption or placement for adoption following our receipt of the completed *Employee Enrollment* application.

A child will be considered adopted from the earlier of: 1) the moment of placement in a group member's home; or 2) the date of an entry of an order granting custody of the child to the group member. The child will continue to be considered adopted unless the child is removed from the member's home prior to issuance of a legal decree of adoption.

Note: If both parents are covered subscribers through the same employer, their children may be covered as dependents of either, but not both, of the subscribers. Parents have 60 days from the time of the birth, adoption or placement for adoption to submit applications for their dependent children. New spouses and/or domestic partners also have 60 days from date of marriage or affidavit of domestic partnership.

Federal regulations

- Federal TEFRA, DEFRA and COBRA legislation has been enacted to regulate employee health care coverage. Based on this legislation and the limitations of the Anthem agreement, if a business employs, on average, fewer than 20 employees in a year and any employee becomes age 65, then his or her primary carrier must be Medicare. For these employees who are 65 years old and choose to retain their Anthem Small Group coverage, Anthem will apply contract benefits as a secondary carrier for Medicare benefits paid or payable.
- When a member is covered by both Medicare and Anthem, and Anthem is secondary, the total benefit provided by Medicare and Anthem should equal but not exceed the benefits of group members who do not have Medicare coverage.

- Anthem is secondary to Medicare when one of the following criteria is met:
  - If a member is required to pay an additional premium for any part of Medicare and chooses not to enroll in that part, Anthem will pay per contract benefits as primary.
  - If a member is eligible for any part of Medicare that is premium-free and chooses not to enroll in that part, Medicare would be considered primary and the member's Anthem plan would be secondary. Anthem will estimate Medicare's benefit prior to Anthem coordinating coverage for deductibles and coinsurance.

  Anthem is secondary to Medicare when the following criteria are met:
  - The employer has fewer than 20 employees and the member is age 65.
  - Members under 65 are eligible for Medicare due to a disability.
  - Members are enrolled following the first 30 months of kidney dialysis treatments for end-stage renal disease (ESRD).
- COBRA — Participation in the employee's benefit plan, as well as coverage under whatever medical programs are provided by the employer to employees and their dependents, may be continued under a federal law known as COBRA for groups that employ 20 or more employees for at least 50% of the previous calendar year. The employer is responsible for administration (within the guidelines established by the federal government for compliance by employer groups).

State regulations

Cal-COBRA (SB719) took effect January 1, 1998. This legislation provides for the continuation of coverage for employees and eligible dependents of qualifying groups with 2-19 employees.

Under California law AB1401, Cal-COBRA provides continuation of coverage for groups of 2-19 eligible employees for at least 50% of the working days in the preceding calendar year. Groups of one employee are not eligible for Cal-COBRA. An employee and/or his or her eligible dependents are eligible for continuation of coverage under Cal-COBRA for up to 36 months (if they were enrolled in Cal-COBRA on or after January 1, 2003), if coverage was terminated due to any of the following qualifying events:

- Death of the plan subscriber (continuation for dependents)
- Employee's termination of employment or reduction in hours
- Spouse's divorce or legal separation from the subscriber
- Loss of eligible dependent status of an enrolled child
- Subscriber becoming entitled to Medicare
- Loss of eligible status of enrolled family member

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

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

Effective January 1, 2008, AB910 amended existing law to extend the continuation of coverage rights for over-age dependents who are: 1) incapable of self-sustaining employment by reason of physically or mentally disabling injury, illness or condition; and 2) chiefly dependent on the subscriber for support and maintenance. The law sets out new notification timelines, and requires subsequent health care service plans and health insurers to honor continued coverage unless there is a demonstration that the child no longer meets eligibility requirements.

California underwriting business requirements

Sole proprietors

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

Sole proprietors must provide all of the following:

- California business license or fictitious business name filing
- Anthem *Eligibility Statement*
- *Quarterly State Tax Withholding Report*, if available
- If the owner is not listed showing wages on the *Quarterly State Tax Withholding Report*, the group will also need to provide a current *Schedule C* or *Schedule F for Farms* (If this is not available due to the length of time in business or because there is an extension to file, a California business license or fictitious business name filing may be substituted.)

  Owners and spouses or domestic partners of officers or partners do not constitute common-law employees.

Corporations

Corporations must provide all of the following:

- *Statement of Information (Articles of Incorporation with stamped meeting minutes listing names of the officers may be considered)*
- Anthem *Eligibility Statement for enrolling officers not on the quarterly wage report*
- *Quarterly State Tax Withholding Report*, if available, or some other objective indicia of employment
- *Tax Form 1120* with *Schedule 1125E* (for C Corp)
- *Schedule K-1*

Corporations established out of state will also need to provide a *Certificate of Qualification* or *Statement by Foreign Corporation* in addition to the above documentation.

If the percentage of ownership is zero, the enrolling corporate officer must appear on the *Quarterly State Tax Withholding Report*.

Two percent S Corp shareholders, owners and spouses or domestic partners of officers or partners do not constitute common-law employees.

Partnerships

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

Partnerships must provide all of the following:

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

Owners and spouses or domestic partners of officers or partners do not constitute common-law employees.

Limited partnerships (LPs)

Limited partnerships must provide all of the following:

- *Current Schedule K–1* (If this is not available due to the length of time in business or because there is an extension to file, a *Partnership Agreement* and federal tax ID appointment letter may be substituted.)
- Anthem *Eligibility Statement*
- *Quarterly State Tax Withholding Report*, if available, or some other objective indicia of employment
- If *Limited or General Partners* are not listed showing wages on the *Quarterly State Tax Withholding Report*, the group will also need to provide a current *Schedule K–1* (If this is not available due to the length of time in business or because there is an extension to file, a *Partnership Agreement* and federal tax ID appointment letter may be substituted.)

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

Owners and spouses or domestic partners of officers or partners do not constitute common-law employees.

Limited liability partnerships (LLPs)

Limited liability partnerships (LLPs) must provide all of the following:

- *Partnership Agreement* and federal tax ID appointment letter may be required
- Anthem *Eligibility Statement*
- *Quarterly State Tax Withholding Report*, if available, or some other objective indicia of employment
- If partners are not listed showing wages on the *Quarterly State Tax Withholding Report*, the group will also need to provide a current *Schedule K–1* (If this is not available due to the length of time in business or because there is an extension to file, a *Partnership Agreement* and federal tax ID appointment letter may be substituted.)

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

Owners and spouses or domestic partners of officers or partners do not constitute common-law employees.

Limited liability companies (LLCs)

Limited liability companies (LLCs) must provide all of the following:

- Articles of Organization with Operating Agreement or Statement of Information
- Anthem *Eligibility Statement*
- *Quarterly State Tax Withholding Report,* if available, or some other objective indicia of employment
- If managing members are not listed showing wages on the *Quarterly State Tax Withholding Report*, the group will also need to provide a current Schedule K–1 (If this is not available due to the length of time in business or because there is an extension to file, a *Partnership Agreement* and federal tax ID appointment letter may be substituted.)

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

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

Owners and spouses or domestic partners of officers or partners do not constitute common-law employees.

Start-up companies

A start-up group can be considered for Small Group coverage.

- Refer to page 4, "group eligibility requirements."
- Complete and submit *Conditions of Enrollment/Start-Up Companies/PEO Spin-Off Groups* form.
- Group must provide the first 30 days of payroll within 45 days of the effective date.

Owners and spouses or domestic partners of officers or partners do not constitute common-law employees.

Professional employer organization (PEO) spin-off groups

Employees associated with a PEO are employed by the business listing the employees on its DE9C. A business leasing employees from a PEO cannot cover these employees under Anthem group coverage:

- Refer to page 4, "group eligibility requirements."
- Group must provide a copy of PEO client invoice billed to the worksite business, which includes names of each employee previously leased to the worksite employer.
- Group must sign *Conditions of Enrollment/Start-Up Companies/PEO Spin-Off Groups* form.

Union versus nonunion

- Refer to page 4, "group eligibility requirements."
- A copy of the union roster will be required from the employer identifying union members.
- Groups that exceed 100 employees (combined number of union and nonunion employees) may be considered for Large Group eligibility.

Churches

- Refer to page 4, "group eligibility requirements."
- Members of the clergy who do not appear on the *Quarterly State Tax Withholding Report* should submit a *Schedule SE* or *Form 4361* with IRS approval.

Households

- Refer to page 4, "group eligibility requirements," and the types of groups on pages 15-17.
  - Private household employers who pay annual, rather than quarterly, withholdings will not be eligible.

California underwriting business requirements

Open enrollment period

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

Does not apply to life and disability coverage. See, page 9 for more information.

Benefit modifications

Group level

Anthem can process your group's benefit modification 30 days prior to the group's anniversary date. The following guidelines apply:

- Adding or downgrading a medical plan will only be allowed at the group's anniversary.
- Increases in life benefits may be subject to Life Underwriting approval.
- Employers can make contribution changes once in a 12-month period, subject to Anthem guidelines.
- Anthem must be notified of changes in company name, ownership or tax ID number. These changes are subject to Anthem review and approval.

Note: Refer to the "Benefit modification job aid" (pages 18-21) to determine when each type of benefit modification may be requested and which documents must accompany your request.

Member level

- Covered members may move to a different product offered by their group at the group's anniversary month.
- A member can request a change in medical benefits by completing the *Employee Change Request Form* during the group's anniversary month.

General underwriting guidelines for existing business

Benefit modification job aid

Benefit modification	When eligible	Documents necessary
Add or downgrade a medical plan	At a group's anniversary only	1. Letter/email from the group signed by owner/officer or renewal documents, if available 2. *Employee Applications* for any new enrollments who are not currently enrolled, or renewal documents, if available
Add Dental Net (DHMO) for 2-100 (a minimum of two employees must enroll)	First of the month following receipt of all documentation	1. Letter/email from the group signed by owner/officer, including contribution amount, or renewal documents 2. *Employee Applications* for any new enrollments who are not currently enrolled, or renewal documents, if available 3. Dental Net (DHMO) office numbers
Add Essential Choice PPO plans for 2-100 (a minimum of two employees must enroll; participation requirements apply) **2–4 eligible employees**: 65% of eligible employees not covered by another dental plan (and a minimum of two employees) are required to enroll. **5–100 eligible employees**: A minimum of 25% net eligible of employees not covered by another dental plan are required to enroll. A minimum of two employees must enroll. Dual option (employer can select two plans to offer to employees) is available for groups with at least 10 net eligible employees. A minimum of two employees must enroll in each of the two options and the two plans offered must have a 10% premium differential.	First of the month following receipt of all documentation	1. Letter/email from the group signed by owner/officer 2. New *Employer Application* – SIC code required 3. *Employee Applications* for any new enrollments who are not currently enrolled, or renewal documents, if available 4. A copy of the agent quote: https://brokerportal.anthem.com/ehb/web/bkr/acc/login.htm 5. Rates are based on the eligible employee count
Add voluntary Dental Net DHMO 5-100*	First of the month following receipt of all documentation	1. Letter/email from the group signed by owner/officer, including contribution amount, or renewal documents 2. *Employee Applications* for any new enrollments who are not currently enrolled, or renewal documents, if available 3. Dental Net (DHMO) provider office numbers 4. Copy of agent quote: https://brokerportal.anthem.com/ehb/web/bkr/acc/login.htm 5. SIC code required 6. Rates based on eligible employee count
Add voluntary Essential Choice PPO 5-100 A maximum of two plans can be chosen; cannot be paired with an employer-sponsored plan. **Note**: A minimum of five employees must enroll (there is no participation percentage requirement for our voluntary plans with a minimum of five enrollments in each plan). The two plans offered must have a 10% premium differential.	First of the month following receipt of all documentation	1. Letter/email from the group signed by owner/officer 2. New *Employer Application* 3. *Employee Applications* for any new enrollments who are not currently enrolled, or renewal documents, if available 4. Copy of agent quote: https://brokerportal.anthem.com/ehb/web/bkr/acc/login.htm 5. SIC code required 6. Rates based on eligible employee count

General underwriting guidelines for existing business

Benefit modification	When eligible	Documents necessary
Add employer vision 2-100 (a minimum of two employees must enroll; participation requirements apply) A maximum of two plans may be chosen and cannot be paired with a voluntary vision plan. **Note**: Canceled Blue View Vision coverage can only be re-added at anniversary date.	First of the month following receipt of all documentation	1. Letter/email from the group signed by owner/officer, including contribution amount 2. *Employee Applications* for any new enrollments who are not currently enrolled, or renewal documents, if available 3. Copy of agent quote: https://brokerportal.anthem.com/ehb/web/bkr/acc/login.htm 4. SIC code required 5. Rates based on eligible employee count
Add voluntary vision 5-100 (a minimum of five employees must enroll; participation requirements apply) A maximum of two plans can be chosen; cannot be paired with an employer-sponsored plan. **Note**: Canceled Blue View Vision coverage can only be re-added at anniversary date.	First of the month following receipt of all documentation	1. Letter/email from the group signed by owner/officer 2. *Employee Applications* for any new enrollments who are not currently enrolled, or renewal documents, if available 3. SIC code required 4. Rates based on eligible employee count
Add employee basic life insurance The following amounts are guaranteed issue: $50,000 for 2-9 enrolled. Varies by group – see proposal for 10-100 enrolled. Coverage amounts over guaranteed issue are subject to Life Underwriting approval. For full explanation of eligibility, please see pages 9-13 of this guide.	First of the month following receipt of all documentation	1. Letter/email from the group signed by owner/officer 2. New *Employer Application* 3. *Employee Applications* for any new enrollments who are not currently enrolled, or renewal documents, if available 4. Evidence of Insurability for any amount over guaranteed issue 5. SIC code required 6. Copy of agent quote: https://brokerportal.anthem.com/ehb/web/bkr/acc/login.htm
Add dependent life coverage **Groups of 2-9**: $10,000 spouse/$5,000 child age 15 days to 26 years $5,000 spouse/$2,500 child age 15 days to 26 years **Groups of 10-100:** $20,000 spouse/$10,000 child age 15 days to 26 years $15,000 spouse/$7,500 each child $10,000 spouse/$5,000 child age 15 days to 26 years $5,000 spouse/$2,500 child age 15 days to 26 years $2,000 spouse/$1,000 child **Note**: Dependent child coverage is applicable for ages 15 days to 26 years. For full explanation of eligibility, please see pages 9-13 of this guide.	First of the month following receipt of all documentation	1. Letter/email from the group signed by owner/officer, including desired dependent life amount and contribution amount 2. New *Employer Application* 3. *Employee Applications* for any new enrollments who are not currently enrolled, or renewal documents, if available 4. Copy of agent quote: https://brokerportal.anthem.com/ehb/web/bkr/acc/login.htm **Note:** Employee must purchase basic life/AD&D to be eligible for dependent life.

Benefit modification	When eligible	Documents necessary
Add optional life coverage Available only to groups with 10 or more employees. (Participation requirements will apply: Greater of 20% of eligible employees or five employees must enroll.) **Add optional dependent life coverage** Available when selecting optional life **Add long-term disability and short-term disability products 10-100** 75% of eligible employees (100% required if noncontributory) **Voluntary life** Available only to groups with 10 or more employees. (Participation requirements will apply: Greater of 20% of eligible employees or five employees must enroll.) **Voluntary short-term disability** Available only to groups with 10 or more employees. (Participation requirements will apply: Greater of 20% of eligible employees or 10 employees must enroll.) **Voluntary long-term disability** Available only to groups with 10 or more employees. (Participation requirements will apply: Greater of 20% of eligible employees or 10 employees must enroll.) For full explanation of eligibility, please see pages 9-13 of this guide.	First of the month following receipt of all documentation	1. Letter/email from the group signed by owner/officer 2. New *Employer Application* 3. *Employee Applications* for any new enrollments who are not currently enrolled 4. *Evidence of Insurability* form 5. Copy of agent quote: https://brokerportal.anthem.com/ehb/web/bkr/acc/login.htm
Add part-time employee eligibility Does not apply to life and disability coverage.	First of the month following receipt of all documentation	1. Letter/email from the group signed by owner/officer 2. *Employee Enrollment Application(s)*, requesting or declining coverage for all eligible part-time employees 3. New *Employer Application* 4. Current *Quarterly State Tax Withholding Report* reconciled 5. *Attestation* form **Note**: Additional documentation and review may be required.
Change contribution option	Once in a 12-month period; effective first of the month following receipt of documentation	1. Letter/email from group's owner/officer requesting the change
Group demographic changes **Name change** with same owner and no new enrollments	First of the month following receipt of all documentation	1. Letter/email from group signed by owner/officer requesting the name change 2. Fictitious Business Name Filing (sole proprietorship or partnership), or amended Articles of Incorporation (corporations), or amended Articles of Organization (Limited Liability Corp [LLC]) 3. New *Employer Application* **Note**: Additional documentation and review may be required.
Name change with new ownership and enrollment changes	First of the month following receipt of all documentation	1. Letter/email from group signed by owner/officer requesting the name change 2. New *Employer Application* 3. *Employee Applications* for new owners along with the Eligibility Statement completed in full 4. Purchase Agreement, Federal Tax ID Letter, Fictitious Business Name Filing (sole proprietorship or partnership), or amended Articles of Incorporation (corporations), or amended Articles of Organization (Limited Liability Corp [LLC]) **Note**: Additional documentation and review may be required.

General underwriting guidelines for existing business

Benefit modification	When eligible	Documents necessary
Splits If the company maintains or inherits the same employees (covered prior to the split)	First of the month following receipt of all documentation	1. Letter/email from group signed by owner/officer requesting the name change 2. New *Employer Application* 3. *Employee Applications* for those enrolling in the new entity 4. Federal Tax ID Letter, Fictitious Business Name Filing (sole proprietorship or partnership), or Articles of Incorporation (corporations), or Articles of Organization (Limited Liability Corp [LLC]) 5. The most recent *Quarterly Wage and Withholding Report* for the original company indicating the status of each employee and who is going where 6. Eligibility Statement for owners not listed on *Quarterly Wage and Withholding Report* **Note**: Additional documentation and review may be required.
Mergers If a company insured with Anthem is merging with another company also insured by Anthem	First of the month following receipt of all documentation	1. Letter/email from owner/officer of surviving group explaining and requesting the change 2. New *Employer Application* 3. Legal documentation of the merger 4. The most recent *Quarterly Wage and Withholding Report* from each company, with the status of each employee 5. *Employee Applications* for all new employees enrolling or declining coverage 6. Eligibility Statement for owners not listed on *Quarterly Wage and Withholding Report* along with documentation of ownership 7. Prior carrier bill **Note**: Additional documentation and review may be required.
Acquisition If a company insured with Anthem is acquiring another company also insured with Anthem	First of the month following receipt of all documentation	1. Letter/email from group signed by owner/officer explaining and requesting the change 2. Legal documentation of the acquisition 3. The most recent *Quarterly Wage and Withholding Report*, with the status of each employee 4. New *Employer Application* 5. *Employee Applications* for all new employees enrolling or waiving coverage 6. Prior carrier bill from acquired company **Note**: Additional documentation and review may be required.
Acquisition If a company insured with Anthem is acquiring another company **not** insured with Anthem	First of the month following receipt of all documentation	1. Letter/email from group signed by owner/officer explaining and requesting the change 2. Legal documentation of the acquisition 3. The most recent *Quarterly Wage and Withholding Report*, with the status of each employee 4. New *Employer Application* 5. *Employee Applications* for all new employees enrolling or waiving coverage 6. Prior carrier bill from acquired company **Note**: Additional documentation and review may be required.

Definitions

1. **Late enrollee** — A late enrollee is an eligible employee or dependent who has declined enrollment in a health benefit plan offered by a small employer at the time of the initial enrollment period provided under the terms of the health benefit plan, and who subsequently requests enrollment in a health plan of that small employer, except where the employee or dependent qualifies for a special enrollment period provided that the initial enrollment period will be a period of at least 30 days.

   Late enrollees may need to wait until the next open enrollment period to be eligible for coverage.

2. **Guaranteed association** — A nonprofit organization composed of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria, and that: 1) includes one or more small employers as defined in subparagraph (A) of paragraph (1) of subdivision (k) of Health and Safety code 1357.500; 2) does not condition membership directly or indirectly on the health or claims history of any person; 3) uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues will not depend on whether the member applies for or purchases insurance offered to the association; 4) is organized and maintained in good faith for purposes unrelated to insurance; 5) was in active existence on January 1, 1992, and for at least five years prior to that date; 6) has included health insurance as a membership benefit for at least five years prior to January 1, 1992; 7) has a constitution and bylaws, or other analogous governing documents, that provide for election of the governing board of the association by its members; 8) offers any plan contract that is purchased to all individual members and employer members in this state; 9) includes any member choosing to enroll in the plan contracts offered to the association provided that the member has agreed to make the required premium payments; and 10) covers at least 1,000 persons with the health care service plan with which it contracts. The requirement of 1,000 persons may be met if component chapters of a statewide association contracting separately with the same carrier cover at least 1,000 persons in the aggregate.

3. **Qualified event enrollment period** — An eligible employee or dependent should not be considered a late enrollee if the individual meets any of the following criteria:

   - He or she, or his or her dependent loses minimum essential coverage, as described in California Health and Safety Code Section 1357.500 (d).
   - He or she gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption.
   - He or she is mandated to be covered as a dependent pursuant to a valid state or federal court order.
   - He or she has been released from incarceration.
   - His or her health coverage issuer substantially violated a material provision of the health coverage contract.
   - He or she gains access to new health benefit plans as a result of a permanent move.
   - He or she was receiving services from a contracting provider under another health benefit plan for one of the conditions described in subdivision (c) of Health and Safety Code Section 1373.96 and that provider is no longer participating in the health benefit plan.
   - He or she is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service.
   - He or she demonstrates that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period because he or she was misinformed that he or she was covered under minimum essential coverage.

   Note: Coverage for individuals who apply during one of the specified special enrollment periods becomes effective:

   - No later than the first day of the first calendar month beginning after the date the plan receives the request for special enrollment.
   - You have within 60 days from the qualifying event(s) to enroll.

4. **New hires** — Employees in groups who are hired after the group's effective date.

5. **Takeover group/members** — All the eligible employees/dependents of an employer group who were covered as a group by a prior carrier.

Notes

Health · Pharmacy · Dental · Vision · Life · Disability

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