**Small Group Underwriting for Nevada**
Anthem Blue Cross and Blue Shield
9133 W. Russell Road
Las Vegas, NV 89148

**Overnight delivery**
Anthem Blue Cross and Blue Shield
Small Group Sales
9133 W. Russell Road
Las Vegas, NV 89148
**Phone:** 702-586-6306

**Small Group Member Customer Service**
**Phone:** 877-833-5734
**Hours of operation:** Monday – Friday, 6:30 a.m. – 4:30 p.m. PST

**Broker Support Team**
9133 W. Russell Road
Las Vegas, NV 89148
**Phone:** 888-445-9236
**Fax:** 888-819-7475
**E-mail:** nvsgbroker@anthem.com
**Hours of operation:**
Monday – Friday, 8 a.m. – 5 p.m. PST

**Group Administrator**
Anthem Blue Cross and Blue Shield
Membership Department
P.O. Box 172405
Denver, CO 80217-2405
**Phone:** 303-831-2098 or 800-922-4770
**Hours of operation:**
Monday – Wednesday and Friday, 7 a.m. – 4:30 p.m. PST
Thursday, 7 a.m. – 2:15 p.m. and 3:30 – 4:30 p.m. PST

**Website:** anthem.com
### Important Contact Information

<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
</tbody>
</table>

### Section 1  Overview of the Underwriting Process

<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requirements for completing forms</td>
<td>4</td>
</tr>
<tr>
<td>Guidelines for completing forms</td>
<td>4</td>
</tr>
<tr>
<td>Process</td>
<td>4</td>
</tr>
<tr>
<td>Processing time specifications</td>
<td>4</td>
</tr>
<tr>
<td>Evaluation criteria</td>
<td>5</td>
</tr>
</tbody>
</table>

### Section 2  General Underwriting Guidelines for New Business

<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group eligibility requirements</td>
<td>6</td>
</tr>
<tr>
<td>Employer/employee relationship</td>
<td>6</td>
</tr>
<tr>
<td>Ineligible categories</td>
<td>6</td>
</tr>
<tr>
<td>Contribution</td>
<td>7</td>
</tr>
<tr>
<td>Employee eligibility</td>
<td>7</td>
</tr>
<tr>
<td>Employee participation requirements</td>
<td>7</td>
</tr>
<tr>
<td>Health underwriting</td>
<td>8</td>
</tr>
<tr>
<td>EmployeeElect health coverage</td>
<td>8</td>
</tr>
<tr>
<td>Dental coverage</td>
<td>8</td>
</tr>
<tr>
<td>Vision coverage</td>
<td>8</td>
</tr>
<tr>
<td>Life coverage</td>
<td>9</td>
</tr>
<tr>
<td>Disability coverage</td>
<td>10</td>
</tr>
<tr>
<td>ProtectionPack</td>
<td>10</td>
</tr>
<tr>
<td>Rating policies</td>
<td>10</td>
</tr>
<tr>
<td>Rate and benefit guarantee</td>
<td>11</td>
</tr>
<tr>
<td>New group eligibility/effective date</td>
<td>11</td>
</tr>
<tr>
<td>Waiting period</td>
<td>11</td>
</tr>
<tr>
<td>Pre-existing conditions</td>
<td>11</td>
</tr>
<tr>
<td>Takeover provisions</td>
<td>12</td>
</tr>
<tr>
<td>Prior deductible credit/annual maximum copayment credit/dental benefit waiting period credit</td>
<td>12</td>
</tr>
<tr>
<td>Eligible dependents</td>
<td>12</td>
</tr>
<tr>
<td>Federal regulations</td>
<td>13</td>
</tr>
<tr>
<td>State regulations</td>
<td>14</td>
</tr>
<tr>
<td>Nevada business structure underwriting requirements</td>
<td>15</td>
</tr>
</tbody>
</table>
### Section 3  General Underwriting Guidelines for Existing Business

- Open enrollment ................................................................. 16
- Contract benefit modifications.............................................. 16
- Plan modification job aid..................................................... 17
- Member add effective dates.................................................. 18
- Group conversion ................................................................. 18
- Life insurance conversion ..................................................... 19

### Section 4  Definitions

- Declination ..................................................................................... 20
- Dependent ...................................................................................... 20
- Late entrant .................................................................................. 20
- New hire ...................................................................................... 20
- Replacement group/members .................................................... 20
- Special enrollment period .......................................................... 20
- Virgin group/members ............................................................... 21
This manual provides Anthem Blue Cross and Blue Shield’s current general Underwriting Guidelines for Small Group business.

If we make any changes to these guidelines, we’ll inform you about the updates as soon as possible.

Only our Small Group underwriters can make the final decision to accept or decline a case, or determine a group’s rate or effective date. Please note that you’re not authorized to bind or guarantee coverage or a specific rate or effective date. Please advise all prospective groups to keep their current coverage until we notify them that we’ve accepted them for coverage.
1. Requirements for completing forms

This documentation is required when you submit new business:

a. A copy of the agent’s quote (based on final enrollment for current [effective] date)

b. The most current Small Group Employer Application (Master Application)

c. The most current Employee Applications from all employees/dependents enrolling

d. Applications from all employees/dependents declining coverage; Sections 1 and 5 of the Employee Application must be completed if declining EmployeeElect coverage

e. A copy of the company’s most recent Nevada Employer’s Quarterly Contribution and Wage Report, which must be justified by showing full-time, part-time, seasonal, not yet eligible, terminated, etc.

f. If it’s a group replacement case, a copy of the last month’s group premium statement

g. The last billing statement listing Consolidated Omnibus Budget Reconciliation Act (COBRA)/Family and Medical Leave Act (FMLA)/Nevada State Continuation subscribers, if applicable

h. An imprinted company check for the first month’s applicable lines of coverage, made payable to Anthem Blue Cross and Blue Shield

i. Submission of 100 percent of the premium with the applications for all applicable lines of coverage

See page 15 for alternative forms to validate business eligibility when the Nevada Employer’s Quarterly Contribution and Wage Report isn’t available.

2. Guidelines for completing forms

Use these guidelines for completing Employer and Employee Applications for groups of 2-50:

a. Answer all questions and make sure all signatures and dates are included. If the group paperwork is incomplete, our underwriter may not be able to complete the underwriting process.

b. For new group submissions, the employee’s signature date can’t be more than 60 days before the requested coverage effective date.

c. Employees can make changes to their Employee Application. They must initial and date any changes they make.

d. See Section 2, page 6, for specific guidelines for groups of 2-50 with only one employee enrolling.

3. Process

Our underwriters evaluate small groups to determine the risk adjustment factor and whether the group qualifies for coverage.

4. Processing time specifications

When you first submit a case to us, make sure all required forms and other documents are completed accurately and included with your submission.

a. We’ll accept new group submissions: 1) with a requested effective date of the first of the month up to the last day of the month before the requested effective date, or 2) with a requested effective date of the 15th of the month up to the 12th of the month before the requested effective date.

b. If we receive incomplete forms, we can’t make a determination until we get all the necessary information.

c. When the information submitted is incomplete and we don’t receive it in a timely manner, we may withdraw the group’s application for the month requested.
5. Evaluation criteria

We base underwriting on the following criteria:

a. Business qualification
b. Employer contribution
c. Health status
d. Employee and dependent eligibility
e. Employee participation
f. Geographic location
g. Tobacco use
h. Age
i. Gender
j. Standard industry classification code
k. Group size

We may decline a group if:

a. A bona fide employer/employee relationship doesn’t exist.
b. More than 50 percent of the group’s eligible employees are employed outside the state of Nevada on 50 percent of the workdays in the last calendar quarter or the last calendar year. See Section 2, Item 1, “Group Eligibility Requirements.”
c. The group isn’t subject to NRS 689B (Nevada Small Group statutes).
d. The group doesn’t meet our eligibility requirements.
e. Other such factors, as determined by Anthem Blue Cross and Blue Shield and subject to applicable law, apply.
1. **Group eligibility requirements**

   Fifty-one percent of all eligible employees must be employed in the state of Nevada. If no state has a numerical majority and the group is headquartered in Nevada, then Nevada Small Group regulations apply:

   a. The group must have a physical location in Nevada.

   b. **Group size 2-50 with one enrolling:** Nevada does not recognize a group with more than one employee when only one enrolls as a small group because the group will not meet the minimum participation requirements in Nevada. Small employer means, with respect to a calendar year and a plan year, an employer who employed on business days during the preceding calendar year an average of at least two employees, but not more than 50 employees, who have a normal workweek of 30 hours or more; and who employs at least two employees on the first day of the plan year. For the purposes of determining the number of eligible employees, organizations that are affiliated or eligible to file a combined tax return for the purposes of taxation constitute one employer. Organizations are “affiliated” if one directly, or indirectly, through one or more intermediaries, controls or is controlled by, or is under common control with, the other, as determined pursuant to the provisions of NRS 692C.050.

   c. Eligible employee means a permanent employee who has a regular working week of 30 or more hours. The term includes a sole proprietor or a partner of a partnership, if the sole proprietor or partner is included as an employee under a health benefit plan of a small employer.

2. **Employer/employee relationship**

   a. An employer/employee relationship must exist. An employee who works at least 30 hours per week is considered a full-time employee. An employee who works less than 30 hours per week is considered a part-time employee and isn’t eligible for coverage.

   b. Persons that the employer compensates on a **1099** basis are eligible for coverage.

   Here are the eligibility requirements for groups with **1099** employees:

   - No more than 50 percent of the group’s employees can be **1099** employees.
   - The **1099** employees must be employed by the company full time and year round.
   - All present and future **1099** employees are subject to the same eligibility requirements as taxed employees.
   - The employer must contribute the same amount for **1099** employees as for all other employees qualifying under **NRS 689C**.
   - The employer must have at least two taxed employees, with tax documents that verify the company is a valid business.
   - The new group submission must include a complete list of all **1099** employees, **and a completed and signed 1099 Addendum Form**.

   c. Temporary, seasonal, part-time and substitute employees aren’t eligible.

   d. If an owner believes the structure of his or her holdings produces a single employer/employee relationship, we’ll require copies of all associated supporting documentation validating 51 percent common ownership of all companies involved. This documentation can be submitted before the case submission. We’ll make the final determination about whether or not there is one responsible employer.

3. **Ineligible categories**

   Associations, multiple-employer trusts, part-time and seasonal employees, retirees, and board of director members and stockholders aren’t eligible for coverage. These categories are defined or explained below:

   a. **Association** (unless qualifying as a guaranteed association): A group of employer units banded together for any reason

   b. **Multiple-employer trust** (unless qualifying as a guaranteed association): Employers, usually in the same or related industries, brought together by an insurer, agent, broker or administrator to provide insurance for their employees under a master contract issued to a trustee under a trust agreement
c. **Part-time employee**: An employee who works less than 30 hours per week.

d. **Seasonal employee**: An employee who regularly works less than 12 consecutive months, but for periods of time that are definite in length and with a formal policy of recall.

e. **Retirees**: May be eligible for Individual conversion or Medicare Supplement products.

f. **Board of director members and stockholders**: Not eligible for coverage unless they’re also officers of the company and working at least 30 hours per week.

4. **Contribution**

Employers can choose how much they’ll contribute to their employees’ health premiums based on the options below. Payroll deduction is required if contributory.

**EmployeeElect health**

a. **Traditional option**: The employer contributes at least 50 percent of each covered employee’s monthly health premium.

b. **Fixed-dollar option**: The employer can contribute a fixed dollar amount of $125 or more, in $5 increments, for each covered employee’s monthly health premium. Certain restrictions and minimums apply.

c. **Percentage-of-plan option**: The employer can choose a specific plan to base a defined percentage on. Certain restrictions and minimums apply.

**State-mandated basic and standard health (not available as part of our EmployeeElect portfolio)**

The employer contributes at least 50 percent of each covered employee’s monthly health premium.

**Dental**

a. If a group purchases dental coverage alone, the employer must contribute at least 50 percent of each covered employee’s monthly dental premium.

b. If a group purchases dental coverage with EmployeeElect health coverage, the employer must contribute at least 25 percent of each covered employee’s monthly dental premium.

**Vision**

The employer must contribute at least 50 percent of each covered employee’s monthly vision premium, if purchased with EmployeeElect health coverage.

**Life and disability**

For basic Life, the employer must contribute at least 25 percent of each covered employee’s monthly Life premium.

5. **Employee eligibility**

To be eligible as an employee, a person must be an active full-time employee with a regularly scheduled workweek of at least 30 hours per week and be compensated for that work by the employer (subject to withholding as it appears on a W-2 form). Sole proprietors, partners, and corporate officers must work at least 30 hours a week to be eligible.

6. **Employee participation requirements**

**Health**

For our EmployeeElect, state-mandated, and actively marketed PPO and HMO health plans, at least 75 percent of the group’s eligible employees must participate. (See Section 2, Items 9-12, for dental, vision, and Life and disability participation requirements.)

Groups must maintain all of their minimum participation levels to remain eligible (100 percent if noncontributory). We may not renew a group if its participation falls below the required minimum.

If an employee waives coverage due to other group coverage through another employer (as a subscriber or a dependent), because the employee has an Individual policy, or because the employee has other qualifying creditable coverage, the employee may be ineligible for the purposes of calculating participation. The employer must submit a declination for these employees.

If a husband and wife both work for the same employer, they can apply separately as employees, or one can be covered as a dependent on the other’s policy. Their children can apply as dependents of either or both employees. The contract holder under a single contract will be the employee whose date of birth falls first in the year.
Section 2  General Underwriting Guidelines for New Business

We may consider classification carve-outs, such as management only or salary vs. nonsalary, with underwriting approval. The new group submission must include a list of the job classifications the employer wants to insure. The list must include all employees and identify all employees in the carved-out classification. If the carve-out groups don’t meet our underwriting criteria, we may decline them.

7. Health underwriting

We’ll underwrite groups of 2-50 according to Nevada laws and regulations, including the criteria outlined in NRS 689C.

Employees in employer groups of 2-50 eligible enrolling employees must complete the health history section on the current EmployeeElect Enrollment Application/Change Form for Small Groups of 2-50.

a. Eligible employees and their dependents waiving coverage at the time of enrollment must complete a waiver of coverage, which includes their name, Social Security or ID number, and the applicable waiver section of the Employee Application, and submit the completed forms to us. We may also require proof of coverage.

b. Late entrants (see Section 4, “Definitions”) can apply for coverage according to the following:

   • HMO Nevada and non-HMO Nevada applicants can only apply during the employer’s open enrollment period.

   c. We don’t accept applications dated more than 60 days before the desired coverage effective date.

   d. Our Underwriting department can usually make an immediate decision if it receives all the required documentation with the new group submission. Please see page 4 for a list of all the documentation that’s required. Missing documentation or premium can delay the underwriting process.

   e. Our Underwriting department usually doesn’t request an attending physician’s medical records. However, we may require additional medical information to determine the risk adjustment factor. If our Underwriting department requests medical records, the applicant must provide the records at his or her expense. The applicant also must provide a Health Insurance Portability and Accountability Act (HIPAA)-compliant authorization.

f. For startup companies, the applicable documentation verifying business eligibility is required (see page 15).

8. EmployeeElect health coverage

Employers may offer one plan, a mix of plans or all the EmployeeElect plans to their employees.

a. Full choice of plans – The EmployeeElect portfolio includes ten PPO plans, seven consumer-driven health (CDH) plans, and five HMO plans.

b. Financial control – The three options for monthly contribution to employees’ health premiums (they pay the rest through payroll deductions) include:
   • Fixed-dollar contribution – Pay as little as $125 per employee.*
   • Traditional contribution – Pay as little as 50 percent per employee.
   • Percentage-of-plan contribution – Choose a specific plan to base a defined percentage on.*

   *Certain restrictions and minimums apply.

9. Dental coverage

Dental coverage is available to groups of 2-50.** Employers can select all plans or make specific plan options available to their employees.

At least 75 percent of the eligible employees must participate when the employer offers stand-alone dental coverage. At least 50 percent participation is required if dental coverage is offered along with EmployeeElect health coverage.

10. Vision coverage

Vision coverage is available to groups of 2-50.** At least 75 percent of the eligible employees must participate when the employer offers vision coverage on a stand-alone basis or along with EmployeeElect health coverage.
11. Life coverage

a. Stand-alone employee and dependent Life is available.

b. The participation requirement is 75 percent of the eligible employees when the employer offers Life coverage on a stand-alone basis or along with EmployeeElect health coverage.

c. The employer must contribute a minimum of 25 percent of the employee's basic Life premium. If the employer pays 100 percent of the basic Life premium, 100 percent participation is required.

d. Stand-alone Life is available to groups of 2-50. A minimum of two employees must enroll.

e. Basic Life is available to groups of 2-50. Life plans with $15,000-$200,000 in coverage are available. Benefit plans may be salary based (1x the employee's annual salary or 2x the employee's annual salary); a flat-dollar amount for all employees; or graded by job title (Class I or II). The benefit amount for Class II cannot exceed 2.5 times the benefit amount for Class I. Accidental death and dismemberment coverage, waiver of premium, a living benefit and conversion coverage are included. Benefits reduce by the following: 35 percent at age 65, 60 percent at age 70, 72 percent at age 75, and 80 percent at age 80. Coverage terminates at retirement.

f. For any life insurance coverage over the guaranteed issue amount, completed health statements are required and coverage is subject to underwriting approval.

g. The guaranteed issue amount is $30,000 for basic life insurance coverage for employer groups with 2-9 eligible enrolling employees.

h. The guaranteed issue amount is $50,000 for basic life insurance coverage for employer groups with 10-24 eligible enrolling employees.

i. Employer groups with 25-50 eligible enrolling employees are guaranteed for up to $100,000 in life insurance coverage.

j. For all groups of 2-50, the basic Life coverage guaranteed issue amount is $25,000 for employees age 70 and over.

k. In addition to the basic Life option, supplemental Life is also available to groups of 2-50, subject to underwriting approval. For groups of two employees, 100 percent participation is required. For groups of 2-50 employees, at least 25 percent of the eligible employees, with a minimum of three enrolling employees, must participate. Coverage options of $15,000, $25,000, $50,000 and $100,000 are available to groups of 10-50 eligible employees. Accidental death and dismemberment coverage, waiver of premium, a living benefit and conversion coverage are included. Benefits reduce by the following: 35 percent at age 65, 60 percent at age 70, 72 percent at age 75, and 80 percent at age 80. Coverage terminates at retirement.

· Supplemental Life is 100 percent employee paid. Supplemental Life is not available on a stand-alone basis. There is no guaranteed issue amount for supplemental Life for groups of 2-9. The guaranteed issue amount is $15,000 for groups of 10-50.

l. Two dependent Life** coverage options are available:

· **Option 1:** Includes $10,000 in coverage for the employee's spouse and $10,000 for each dependent child 15 days to 19 years of age. Continuation-of-coverage rules for children to age 24 are consistent with the health plan’s continuation rules. Spouse coverage terminates when the spouse turns 65. The rate is a flat rate per family unit. Please note that Option 1 is available only if employee Life coverage is $20,000 or more.

· **Option 2:** Includes $5,000 in coverage for the employee's spouse and $5,000 for each dependent child 15 days to 19 years of age. Continuation-of-coverage rules for children to age 24 are consistent with our health plan continuation rules. Spouse coverage terminates when the spouse turns 65. The rate is a flat rate per family unit.

m. Existing employees and new hires must complete the health history section of the Employee Application if the amount chosen is more than the guaranteed issue amount. Life insurance isn't guaranteed and is subject to underwriting approval.

n. Existing health groups that increase the Life coverage amount are subject to underwriting approval, regardless of group size.

** A minimum of two subscribers must enroll in all ancillary products with the exception of ProtectionPack on a voluntary basis and EAP products.
12. Disability coverage

Short-term disability coverage is available to groups of 2-50 lives.

a. Plans available: 1/8/13, 1/8/26 and 15/15/26
b. Benefit amounts available: flat $200/week, 66.67 percent up to $750
c. Only nonoccupational disabilities are covered. Coverage for pregnancy is the same as coverage for any illness. There are no pre-existing condition limitations.
d. Guaranteed issue:
   - 2-5 lives: None
   - 6-9 lives: $500/week
   - 10-50 lives: All amounts are guaranteed issue.
e. Participation requirements:
   - Contributory: 75 percent
   - Noncontributory: 100 percent
f. Rates are per each $10 in weekly benefits.

Long-term disability is available to groups of 2-50 lives.

a. Plans available:
   - Gold: Age 65/RBD, 60 percent to $6,000, 90-day elimination period
   - Gold: Age 65/RBD, 60 percent to $6,000, 180-day elimination period
   - Silver: five-year/RBD, 60 percent to $6,000, 90-day elimination period
   - Silver: five-year/RBD, 60 percent to $6,000, 180-day elimination period
   - Bronze: two-year/RBD, 50 percent to $3,000, 180-day elimination period
b. Guaranteed issue:
   - 2-5 lives: None
   - 6-50 lives: All amounts are guaranteed issue.
c. Participation requirements:
   - Contributory: 75 percent
   - Noncontributory: 100 percent
d. Rates are per each $100 of monthly covered payroll.

13. ProtectionPack

ProtectionPack is available to groups of 2-50 lives.

a. Five fixed-price options, consisting of Life, accidental death and dismemberment, short-term disability and long-term disability coverage, as well as an employee assistance program, are available.

b. ProtectionPack is only available on a non-contributory basis, at a per-employee flat rate, in three age bands.

14. Rating policies

a. All rates are based on the group’s actual enrollment.

b. Our underwriter will determine the group’s acceptance, final rates and effective date.
15. Rate and benefit guarantee
   a. Health plan rates are guaranteed for a maximum of 12 months.
   b. We may change health plan rates and benefits with a 60-day advance written notice or, when the change is mandated by law, without advance notice.
   c. Changes to the risk adjustment factor are limited, as defined by Nevada law.
   d. Rates for stand-alone dental, vision and Life coverage are guaranteed for 12 months.
   e. Rates for dental, vision or Life coverage written in conjunction with health coverage will receive the health rate guarantee.
   f. For new business, we’ll issue age rates to groups with 2-4 eligible employees enrolling in a health plan. We’ll issue composite rates, if desired, to groups with 5 or more eligible employees enrolling.

16. New group eligibility/effective date
   a. The eligibility date for existing employees and dependents is the employer’s effective date, unless new hires haven’t yet satisfied their employer’s waiting-period requirements. The effective date for these employees will be the first of the month after their completed Enrollment Application is submitted, unless they are a late entrant.
   b. Employers can waive the waiting period for all new hires when the group initially enrolls.
   c. Employer groups of 2-50 aren’t guaranteed an effective date.

17. Waiting period
   For future employees, employers can designate their waiting period as the first of the month following the employee’s hire date, or one, two, three, four, five, six or 12 months after the employee’s hire date. A future employee’s coverage eligibility date is always the first day of the month after the waiting period is completed. We won’t waive the waiting period for any future employees.

18. Pre-existing conditions
   a. When applicable, we impose pre-existing condition limitations for up to six months after the coverage effective date. We apply those limitations to conditions for which the applicant sought or received care within six months of the enrollment date. Pre-existing condition limitations aren’t applicable to newborn and adopted children. Pregnancy isn’t subject to any pre-existing condition limitations.
   b. We provide credit for prior creditable health or dental coverage (including Individual, Group or state-sponsored programs) in accordance with HIPAA. We may require verification.
   c. Our HMO Nevada plans have no pre-existing condition limitations.
   d. New hires and re-enrollees can also be subject to pre-existing condition limitations. Late entrants can be subject to pre-existing condition limitations for up to six months.

Note: The “look-back” period for pre-existing conditions begins with the enrollment date (usually the hire date, not the effective date).
19. Takeover provisions

A policy of group health insurance issued to replace any discontinued policy or coverage for group health insurance must:

a. Provide coverage for all persons who were covered under the previous policy or coverage on the date it was discontinued; and

b. Provide benefits that are at least as extensive as the benefits provided by the previous policy or coverage, except these benefits may be reduced or excluded to the extent that such a reduction or exclusion was permissible under the terms of the previous policy or coverage, if that replacement policy is issued within 63 days after the date on which the previous policy or coverage was discontinued.

If an employer obtains a replacement policy to cover his employees, any benefits provided by the previous policy or coverage may be reduced if notice of the reduction is given to his employees. Any insurer who issues a replacement policy may submit a written request to the insurer who provided the previous policy or coverage for a statement of benefits that were provided under that policy or coverage. Upon receiving such a request, the insurer who provided the previous policy or coverage will give a written statement to the insurer providing the replacement policy that indicates what benefits were provided and what exclusions or reductions were in effect under the previous policy or coverage.

The provisions of this section apply to a self-insured employer who provides health benefits to his employees and replaces those benefits with a policy of group health insurance but do not apply to the Public Employees’ Benefits Program established pursuant to NRS 287.0402 to 287.049:


20. Prior deductible credit/annual maximum copayment credit/dental benefit waiting-period credit

a. For new group submissions, we provide credit for deductibles met under prior group health or prior group dental coverage, if proof of the actual dollar amount is submitted with the first claim or before 180 days, whichever comes first.

b. We provide credit for deductibles met under our health or dental plans.

c. Credit for pharmacy deductibles isn’t available.

d. Credit for annual maximum copayments isn’t available.

21. Eligible dependents

Dependent coverage is available to the following:

a. Lawful spouse
b. Unmarried natural child
c. Newborn child
d. Legally adopted child
e. Stepchild
f. Ward of legal guardian
g. Grandchild of eligible dependent
h. Other such classifications, as required by law or regulation

See Section 4, “Definitions,” for specific age criteria.
22. Federal regulations

a. Federal Tax Equity and Fiscal Responsibility Act (TEFRA), Deficit Reduction Act (DEFRA) and COBRA legislation regulates employee health care coverage. Based on this legislation and our Agreement with the employer, if a business employs, on average, fewer than 20 employees in a year and any employee turns 65 years of age, his or her primary health insurance carrier will be Medicare. For employees who are at least 65 years old and who choose to keep their Anthem Blue Cross and Blue Shield coverage, we’ll be a secondary carrier for Medicare benefits paid or payable.

b. If a member is covered by Medicare and Anthem Blue Cross and Blue Shield, and we’re secondary to Medicare, the Medicare payment is calculated first and we coordinate up to 100 percent of coverage for deductibles and coinsurance, not to exceed the Anthem benefit.

c. Anthem Blue Cross and Blue Shield is secondary to Medicare when the following criteria are met:
   - The employer has fewer than 20 employees and the member is at least age 65; or
   - The employer has fewer than 20 employees and the member under age 65 is eligible for Medicare due to a disability; or
   - The member enrolled following the first 30 months of kidney dialysis treatments for end-stage renal disease.

d. COBRA: Participation in the employer’s benefit plan, as well as coverage under whatever medical programs are provided by the employer to employees and their dependents, can be continued under a federal law known as COBRA for groups that employ 20 or more employees for at least 50 percent of the previous calendar year.

The employer is responsible for administration within the guidelines established by the federal government for compliance by employer groups.

Special coordination of benefits (COB) rules may apply, specifically for Medicare secondary payer situations. The group’s certificate contains additional details about COB rules.
23. State regulations

Nevada State Continuation (NRS 689B 245-249) provides for continuation of coverage for employees and their eligible dependents of qualifying groups (i.e., groups that on at least 50 percent of the working days during the previous calendar quarter employed 2-19 eligible employees). Employees must have been continuously covered under the employer’s plan for 12 consecutive months and must have been involuntarily terminated from the group health policy. Group conversion is available if the employee was covered for at least three months (NRS 689B 245-249)(2)(c).

We don’t administer State Continuation coverage.
24. Nevada business structure underwriting requirements

<table>
<thead>
<tr>
<th>Business type</th>
<th>In business more than 3 months</th>
<th>In business less than 3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>C Corporation</td>
<td>Nevada Employer's Quarterly Contribution and Wage Report</td>
<td>Payroll records and Articles of Incorporation</td>
</tr>
<tr>
<td>S Corporation</td>
<td>Nevada Employer's Quarterly Contribution and Wage Report or K-1 for shareholder’s income</td>
<td>Payroll records and Articles of Incorporation</td>
</tr>
<tr>
<td>Partnership</td>
<td>K-1 for partner’s income or Schedule SE (self-employment tax) or Form 1065 Partnership Return and Nevada Employer’s Quarterly Contribution and Wage Report for employees</td>
<td>Partnership Agreement and SS-4 (application for tax ID) and payroll records</td>
</tr>
<tr>
<td>Limited Liability Company (LLC)</td>
<td>May file as either a C Corporation or a Partnership (refer to above)</td>
<td>May file as either a C Corporation owner or a Partnership (refer to above)</td>
</tr>
<tr>
<td>Sole Proprietorship</td>
<td>Schedule SE and Schedule C filed with Form 1040 (tax return) and Nevada Employer’s Quarterly Contribution and Wage Report for salaried employees</td>
<td>Payroll records and SS-4 or appropriate tax ID verification. A sole proprietor can use a Social Security number instead of getting a new tax ID number.</td>
</tr>
<tr>
<td>Independent Contractor</td>
<td>Signed 1099 addendum and a list of all 1099 employees</td>
<td>Signed 1099 addendum and list of all 1099 employees</td>
</tr>
<tr>
<td>Farm</td>
<td>Form 1040 and Schedule F or K-1. Farms can also file Form 1041, 1065 or 1065B.</td>
<td>Payroll records and SS-4 or Articles of Incorporation, Partnership Agreement, etc.</td>
</tr>
<tr>
<td>Nonprofit Organization</td>
<td>Form 940 or Form 990</td>
<td>Articles of Organization and IRS confirmation of non-profit status</td>
</tr>
<tr>
<td>Startup Group</td>
<td>N/A</td>
<td>Payroll records, business license and Articles of Incorporation</td>
</tr>
</tbody>
</table>

**Note:** We can't accept a brand new business until payroll records are available.
1. **Open enrollment**
   
   An employee or qualified dependent who previously declined coverage and later wants to enroll in HMO Nevada or a PPO plan can do so at the group’s anniversary date. Special enrollment periods may apply. See Section 4, “Definitions,” “Special enrollment period.”

2. **Contract benefit modifications**
   
   **Group level**
   
   Employers can only submit plan change requests at the group’s anniversary date. The required documentation must be complete and accurate before we can process the request. We must receive the completed documentation, including all necessary Anthem forms, at least 30 days before the requested effective date. If we accept the application for benefit modification, our Underwriting department will assign the effective date for the benefit change. Please also see the Plan modification job aid on the next page to determine when an employer can request each type of benefit modification and to determine which documents are required with the request.

   The additional criteria below apply to group-level contract benefit modifications:
   
   a. Increases in Life benefits are subject to underwriting approval.

   b. When an employer adds dental, vision, or Life and disability coverage to an existing health plan policy, rates will default to the health plan rate guarantee after the initial dental, vision or Life rate guarantee expires.

   c. Our underwriter must receive the completed paperwork from groups requesting a benefit modification at least 30 days before the requested effective date. We don’t accept requests for retroactive benefit modifications.

   d. We’ll only consider future requests for changes in the risk adjustment factor on the group’s anniversary date.

   e. Subject to underwriting approval, existing groups can only change their contribution method six months after the original effective date and once in a 12-month period.

   f. The group can’t change its anniversary date.

   g. We must be notified about business ownership or tax ID number changes. These changes are subject to underwriting review.

   h. Changes to our products or portfolios don’t constitute a new rate and guarantee period.

   **Subscriber level**
   
   Covered subscribers can move to a different plan offered by their employer on the anniversary month of the group’s original effective date, or when we approve a group-level benefit change. **Note:** Changes in enrollment can affect composite rates.

   A subscriber requesting a change in health plan coverage must submit an Employee Enrollment Application/Change Form if the employer is offering the plan requested.
### General Underwriting Guidelines for Existing Business  Section 3

**3. Plan modification job aid**

For current Anthem Blue Cross and Blue Shield applications and forms, go to [anthem.com](http://anthem.com).

<table>
<thead>
<tr>
<th>Benefit Modification</th>
<th>When Eligible</th>
<th>Documents Necessary</th>
</tr>
</thead>
</table>
| Add health benefits                                      | On anniversary date                                                            | 1. Employer Application  
2. Letter from the group  
3. Completed EmployeeElect Employee Enrollment Application/Change Form for Small Groups of 2-50 for employees requesting to change or Renewal Change Request Form  
4. Most recent Nevada Employer's Quarterly Contribution and Wage Report reconciled (subject to underwriting approval) |
| Request a change in health benefits that requires underwriting | Six months after the original effective date, once in a 12-month period (on an exception-only basis) | 1. Letter from group (in some circumstances, an EmployeeElect Employee Enrollment Application/Change Form for Small Groups of 2-50 or a Renewal Change Request Form may be required)  
2. Subject to underwriting approval |
| Change in contribution option                            | Six months after the original effective date, once in a 12-month period        | 1. Letter from the group (subject to underwriting approval) |
| Add life insurance or increase existing coverage         | First of the month following receipt of all documentation                      | 1. Employer Application  
2. Letter from the group  
3. New applications for all applicants |
| Add dental/change dental coverage                        | First of the month after we’ve received all documentation                      | 1. Employer Application  
2. Letter from the group  
3. Dental application for all applicants  
4. Proof of prior coverage required for waiting period credit |
| Add BlueView Vision™ coverage                            | First of the month after we’ve received all documentation                      | 1. Employer Application  
2. Letter from the group  
3. Vision application for all applicants |
| Risk adjustment factor change                            | On anniversary date                                                            | 1. Letter from the group  
2. EmployeeElect Employee Enrollment Application/Change Form for Small Groups of 2-50 for all enrollees  
3. Nevada Employer’s Quarterly Contribution and Wage Report reconciled |
| Change in probationary period                            | Six months after the original effective date, once in a 12-month period        | 1. Employer Application  
2. Subject to underwriting approval  
3. Change will affect future (not current) employees |
4. Member add effective dates
   a. Eligible employees can apply for coverage for themselves and their eligible dependents by submitting a completed Employee Enrollment Application/Change Form. Here’s how we then determine the employee’s effective date:
      - We must receive the application within 30 days after the date of hire or within 30 days of the expiration of the employer’s waiting period.
      - If we receive the application before the employee’s waiting period is completed, the effective date will be the same as the eligibility date.
      - If the employee is applying for an HMO Nevada, consumer-driven health plan (CDHP) or a PPO plan, the employee must wait until open enrollment, unless a qualifying event has occurred.
      - If we receive the application more than 30 days after the employee’s eligibility date, the applicant is considered a late entrant and the applicable pre-existing condition limitations and exclusions may apply. A health statement may also be required.
      - **Late Entrant Policy:** Late entrants may enroll only during the employer’s annual renewal enrollment period.
      - Late entrants can be subject to pre-existing condition limitations for up to six months.
   b. Any time an employee or dependent becomes eligible but doesn’t enroll, or if the employee or dependent remains eligible but isn’t keeping coverage, the coverage declination in Section 1 (name and Social Security or ID number) and Section 5 of the EmployeeElect Employee Application must be completed and submitted.
   c. Special enrollment periods are available for newborn children, adopted children, new spouses and wards of legal guardians. They can be added without a waiting period if they are enrolled within 30 days of becoming eligible. In addition, spouses who are eligible, but not enrolled, can also be added in the event of a birth or adoption. An employee who is eligible, but not enrolled, can enroll at the time of marriage, birth, adoption or placement for adoption, which are qualifying events.

5. Group conversion
   a. Members of terminated health plans who qualify for group conversion plans, and individuals whose COBRA or Nevada State Continuation coverage has expired, can apply to Anthem Blue Cross and Blue Shield within 30 days after the termination date for a Conversion Benefit Agreement. The terms, benefits and charges of the conversion plan are different from those of the employer plan. If a member’s previous coverage was with an HMO plan, the member must convert to a Basic or Standard HMO plan. If the prior coverage was a PPO plan, the member must convert to a Basic or Standard PPO plan. Conversion coverage isn’t available to former employees of a group and their dependents if:
      - The employee’s coverage ends because the employer group plan terminated and is replaced within 63 days by another group plan.
      - The employee’s coverage under the employer plan ends because the employee fails to pay any required contributions to premiums.
      - The employee is eligible for group health conversion when coverage under the employer plan ends.
      - The employee is covered by Medicare Part A and/or Part B at the time of eligibility for conversion coverage.
      - The employee is covered by an Individual health plan when coverage ends.
   b. Application for Anthem Blue Cross and Blue Shield conversion coverage is available without a health statement, if there has been no lapse in coverage. We must receive the first quarterly premium and a completed application within 30 days of termination.
6. Life insurance conversion

When an active employee loses group Life coverage due to employment termination or retirement, the employee may have the right to convert from group term life insurance to an individual whole life insurance policy without evidence of insurability. The employee must apply in writing to Anthem Life for conversion, or complete a Notice of Conversion Form and pay the initial premium on the policy within 30 days after the group term life insurance ends.

The employee can choose to be insured for the same or a lesser amount of the insured amount under the group plan. The conversion plan will be effective on the date group term life insurance ends, if the employee applies and pays the conversion premium within the required 30 days. Conversion is also available when an employee loses coverage because the group plan terminates or changes. In these cases, these additional limitations also apply:

- The amount available for conversion is limited to the lesser of $2,000 or the difference between the group Life amount Anthem Life provided and any new group coverage that becomes available during the conversion period.
- The employee must have been covered under the group Life policy for at least five years.
1. **Declination** – A declination is a formal notification to Anthem Blue Cross and Blue Shield that an employee and/or any of the employee’s eligible family members are declining or refusing any coverage. The employee must complete Sections 1 and 5 of the *Employee Elect Employee Application*. A completed declination is required for eligible employees and their dependents who don’t enroll when they become eligible.
   - This information is required to ensure compliance with federal and state laws.

2. **Dependent** – Dependent means a spouse, an unmarried child under 19 years of age, an unmarried child who is a full-time student under 24 years of age and who is financially dependent on the parent, or an unmarried child of any age who is medically certified as disabled and dependent on the parent.
   a. A new spouse or stepchild must complete an application, and pre-existing condition limitations may apply.
   b. An adopted child must be added within 30 days following the date of acceptance of legal responsibility or placement in the physical custody of the adopting parent. Copies of legal documentation must be submitted along with the enrollment.
   c. A newborn child must be added to an existing policy within 30 days after the date of birth. No health questionnaire is required if the newborn child is enrolled within 30 days after the date of birth. Otherwise, the child will be considered a late entrant. Late entrants can be subject to a six-month waiting period and can only enroll in the plan at the group’s anniversary date during open enrollment. Coverage for the eligible grandchild will terminate when the eligible dependent is no longer eligible. An eligible employee may be required to provide proof of parenthood and dependency of the child. Proof of parenthood must be provided by submitting the child’s birth certificate.
   d. A ward of a legal guardian must be added to an existing policy within 30 days following acquisition. An application must be filed within 30 days of issuance of the final court decree or order of permanent legal guardianship. A *Letters of Guardianship Form* from the court, showing the filing date and court seal, must also be filed with the application.
   e. A grandchild of an eligible dependent must be added to an existing policy within 30 days after the date of birth. No health questionnaire is required if the newborn grandchild is enrolled within 30 days after the date of birth. Otherwise, the grandchild will be considered a late entrant. Late entrants can be subject to a six-month waiting period and can only enroll in the plan at the group’s anniversary date during open enrollment. Coverage for the eligible grandchild will terminate when the eligible dependent is no longer eligible.

3. **Late entrant** – A late entrant is an eligible employee or dependent who has declined enrollment in a health plan offered by the employer during the initial enrollment period provided under the terms of the health plan, and who later wants to enroll in a health plan of that employer, if the initial enrollment period is a period of at least 30 days. This also applies to new hires throughout the policy year who have declined coverage and are outside the 30-day window.

4. **New hire** – A new hire is an employee in an employer group who is hired after the group’s coverage effective date.

5. **Replacement group/members** – These are all eligible employees/dependents of an employer group who were covered as a group by a prior carrier.

6. **Special enrollment period** – We won’t consider an eligible employee or dependent a late entrant if the individual meets the criteria under a, b or c below:
   a. He or she was covered by another health plan at the time the individual was eligible to enroll; and
   b. He or she certified at the time of the initial enrollment that coverage by another health plan was the reason for declining enrollment, provided that, if the individual was covered by another health plan, the individual had the opportunity to make the certification and was notified that failure to do so could result in later treatment as a late entrant; and
He or she has lost or will lose coverage under another health plan due to termination of employment of the individual or of a person through whom the individual was covered as a dependent; change in employment status of the individual or of a person through whom the individual was covered as a dependent; termination of the other plan’s coverage; cessation of an employer’s contribution toward an employee’s or dependent’s coverage; death of the person through whom the individual was covered as a dependent; or divorce; and

He or she requests enrollment within 30 days after termination of coverage or employer contribution toward coverage provided by another health plan.

b. A court has ordered that coverage be provided for the spouse or minor child under a covered employee’s health plan, and enrollment is requested within 30 days after the court order is issued.

c. We can’t produce a written statement from the employer stating that, before declining coverage, the individual or the person through whom the individual was eligible for dependent coverage was provided with and signed an acknowledgment of receiving an explicit written notice in boldface type explaining that failure to elect coverage during the initial enrollment period allows us to exclude coverage for 12 months and impose a six-month pre-existing condition waiting period if the individual later decides to elect coverage. (Pre-existing condition waiting periods don’t apply to HMO Nevada plans.)

7. Virgin group/members – These are all eligible employees/dependents of an employer group who have not, as a group, had prior group coverage within the 63 days before the effective date. The probationary period may be waived.