New Hampshire

Benefit Administrator Manual

How to manage your group’s health coverage
Addendum

Effective November 1, 2016, Small Group plans that terminate for nonpayment of premium and wish to reinstate with no break in coverage, must sign up for reoccurring payments in order to reinstate. Exceptions must be approved by the Accounts Receivable Manager.
Table of contents

Section 1 — Introduction ................................................. 4
Welcome ........................................................................... 4
Employer responsibilities ................................................. 4

Section 2 — Important addresses and telephone numbers .......... 6
General correspondence ................................................. 6
Claims ............................................................................. 6
Customer Service ........................................................... 6
Specialty ........................................................................ 6

Section 3 — Eligibility ...................................................... 8
Eligible employees .......................................................... 8

Section 4 — Effective dates ................................................. 9
Open enrollment ............................................................. 9
Employer group benefit conversions ................................. 9
New hires ..................................................................... 9
Special enrollments .......................................................... 10

Section 5 — Enrollment procedures ..................................... 11
How to enroll an employee and eligible dependents .......................... 11
Medicare Secondary Payer (MSP) ...................................... 11
Open/annual enrollment .................................................. 12
New enrollments .............................................................. 12
Enrollment changes .......................................................... 12
Changing contact information ......................................... 15
Correcting dates of birth ................................................. 15
Changing primary care physicians .................................... 15
Moving out of the service area ........................................ 16
Flexible benefits plans (Section 125 plans) ......................... 16
Special enrollment considerations .................................... 16

Section 6 — Electronic enrollment and online tools and resources .... 17
Electronic enrollment advantages .................................... 17
Electronic enrollment options .......................................... 17
Online tools and resources for employers ......................... 18
Online tools and resources for members ............................ 19

Section 7 — Commonly used forms .................................... 20

Section 8 — Claim filing .................................................. 21
Hospital claims .............................................................. 21
Medical/surgical claims .................................................. 21
BlueCard®: the out-of-area program .................................. 22
BlueCard Worldwide program .......................................... 22
Anthem Dental ............................................................... 22
Prescription drug claims .................................................. 23
Home delivery prescription .............................................. 23

Section 9 — Billing .......................................................... 24
Quick reference guide ..................................................... 24

Section 10 — Accounting and terminations ............................ 27
Payment ......................................................................... 27
Reinstatement .................................................................. 28
Retroactive coverage changes ......................................... 28

Section 11 — State and federal law ..................................... 29
NH State Continuation of Coverage (NH C of C) ..................... 29
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) ............................................................. 29
Omnibus Budget Reconciliation Act of 1986 (OBRA) .......... 29
Medicare ......................................................................... 30
Medicare Secondary Payer (MSP) regulations ....................... 30
Medicare and group coverage ......................................... 30
Who is the primary carrier? ............................................. 31
Dual Medicare eligibility ................................................. 32
TEFRA/DEFRA ............................................................... 32
Family Medical Leave Act (FMLA) .................................... 33
Health Insurance Portability and Accountability Act of 1996 (HIPAA) ............................................................... 33

Section 12 — Retirees ....................................................... 34
Obtaining retiree coverage .............................................. 34
Setting up retiree coverage ............................................. 35
Cancelling group retiree coverage .................................... 36
Welcome

Thank you for choosing Anthem Blue Cross and Blue Shield (Anthem). You are important to us, and our first priority is to provide you with prompt, efficient service.

To help you manage your group’s benefit program, we’ve developed this benefit administrator manual. The manual includes summary information on eligibility, enrollment procedures and other important information about your plan. It also gives you step-by-step instructions on how to enroll employees and fill out the appropriate forms, and lists employer responsibilities.

Employer responsibilities

As an employer, your responsibilities include:

- Giving notice of eligibility to each employee who is eligible or will become eligible for enrollment.
- Providing a Summary of Benefits and Coverage (SBC) to employees as part of the open enrollment process, special enrollment event or new hire process. To download your SBC(s) go to:
  - findsbc.com for Small Group non-ACA (legacy) plans and Large Group.
  - sbc.anthem.com for Small Group ACA-compliant plans.
- Obtaining and submitting complete enrollment information for eligible employees wishing to enroll. Incomplete enrollment information will delay enrollment.
- Sending Anthem all applications, notices or other written information or inquiries received from eligible employees.
- Distributing Anthem notices to covered employees.
- Paying premiums on or before their due dates, even though the group requires a contribution toward the premium from covered employees.
- Maintaining a benefits record file of employee applications for each employee. The file should include any changes of classification, benefit amounts and other relevant details when applicable. We may ask for information from time to time that would be contained in the file.
- Reporting to Anthem the following changes and their effective dates:
  - Change in classification.
  - Change in earnings (if benefit amounts are affected).
  - Change in dependent status.
  - Change of employee name.
  - Change of employee address.
  - Termination of coverage and the reason.
  - Change of employer information.
- Assisting insured employees in filing claims, if applicable.
- Giving employees information about COBRA or continuation coverage eligibility, if applicable.
- Reporting to Anthem any of its Qualified Medical Child Support Order (QMCSO) determinations and providing Anthem with copies of such QMCSOs.
- Letting employees know of any conversion eligibility upon termination of employment or when coverage is lost due to other events as stated in your Certificate, if applicable.
- Giving notice to Anthem of changes in group size.

State and federal legislation will change the administration of different aspects of your group health plan, depending on the number of employees in your group. It is important that Anthem receive changes in group size from less than 19, to 20 or more in order to comply with Medicare secondary payer requirements. You should also notify Anthem of changes from 50 to 51+ full-time equivalents (FTEs). Effective 2016, group size is based on the federal counting methodology of FTEs. Please refer to this IRS website for additional information: irs.gov/irb/2011-21_IRB/ar07.html#d0e150
Section 1 — Introduction

- Letting Anthem know if an employee does not meet the eligibility requirements set forth in the “Eligibility Requirements” section of this manual.
- Giving notice to Anthem if an employee is not “actively at work” (as defined in the Certificate) on the date coverage would otherwise be effective.
- Tracking individuals on COBRA, establishing individuals who are no longer eligible for (have used up their time on) COBRA, and notifying Anthem’s billing department about the status of these individuals, if applicable.

**Group participation and contribution requirements**

To avoid adjustment to your group rates, group participation requirements must be met and consistently maintained. Small and Large Groups are subject to a minimum participation requirement of at least 75% of “net eligible” employees. Net eligible employees are the “total eligible” employees minus those eligible employees who have a valid written waiver due to other coverage. Total eligible employees are the sum of all eligible employees.

**Administering Anthem’s dental, vision, life and disability plans**

If you are currently offering an Anthem dental, vision, life and disability plan, please note that Dental Prime and Complete plans are handled separately from your health plan on our own dedicated, industry-leading dental platform. Life and disability plans in most cases are administered separate from your health plan on our dedicated life and disability platform. Blue View Vision™ plans and pediatric dental EHBs are handled the same as your health plan.

Find a copy of the Dental Prime and Complete group administrator manual at anthem.com:

- Choose **Employer**, select **New Hampshire** and choose **Enter**.
- Select **Anthem Dental Prime and Anthem Dental Complete Employer Services**.
- Select **Group Administration Manual**.

Find a copy of the Anthem Life and Disability group administrator manual at anthemlife.com:

- At the home page, select **Answers at Anthem**.
- Select **Group Administration Manual**.

If you have any questions about your group’s benefit program, please refer to the Group Health Care Benefits Contract (GHCBC), Certificate of Coverage or Subscriber Agreement. If you still have questions concerning a specific problem, please contact your Sales representative, Account Service representative or Customer Service department.
Section 2 — Important addresses and telephone numbers

General correspondence
Anthem Blue Cross and Blue Shield
1155 Elm Street, Suite 200
Manchester, NH 03101
1-800-874-7122

Sales and Sales Support
Account representatives/account managers: Dial direct
Small Group Sales Support:
1-800-250-5420
anthembrokersubmissions@anthem.com

Large Group Sales Support:
nhsalesaccountservicereps@anthem.com

Main fax: 1-603-541-2260
Alternate fax: 1-603-541-2266

Enrollment and Billing for Medicomp and Large Group, as well as Small Group non-ACA (legacy) plans
Billing call center:
1-800-273-2521 (press 1)
Collections call center:
1-888-894-8053

Enrollment and Billing fax:
1-877-651-7949

Enrollment and Billing for Small Group ACA-compliant plans
Enrollment and Billing call center:
1-855-250-7763
Enrollment and Billing fax:
1-855-750-2227

Customer Service
For Small Group non-ACA (legacy) plans and Large Group
BlueChoice® (2-and 3-tier):
1-800-438-9672
BlueChoice® New England:
1-800-870-3122

HMO Blue® New England:
1-800-870-3122
Matthew Thornton Blue®:
1-800-870-3057
Indemnity:
1-800-225-2666

CDHP HSA:
1-888-224-4896

Medicomp:
1-800-227-4641

Preferred Blue® PPO:
1-800-852-6592

Customer Service fax:
1-603-541-2252

For Small Group ACA-compliant plans
1-855-748-1805 (on exchange)
1-855-330-1103 (off exchange)

Specialty
Anthem Life and Disability
Customer Service: 1-866-551-0326
Claims service center: 1-800-813-5682
Email: lifeanddisabilityclaims@anthem.com

Life claims
Fax: 1-877-305-3901
Anthem Life Insurance Company
Life Claims Service Center
P.O. Box 105448
Atlanta, GA 30348-5448

Disability claims
Fax: 1-800-850-0017
Anthem Life Insurance Company
Disability Claims Service Center
P.O. Box 105426
Atlanta, GA 30348-5426
Section 2 — Important addresses and telephone numbers

**Anthem Blue View Vision℠**

Customer Service number: 1-866-723-0515

*In-network claims*
Blue View Vision Claim
P.O. Box 8504
Mason, OH 45040-7111

*Out-of-network claims*
Blue View Vision
OON Claims
P.O. Box 8504
Mason, OH 45040-7111
Fax: 1-866-293-7373
oonclaims@eyewearspecialoffers.com

**Online services**
anthem.com
(integrated with health online administration)

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**All other Anthem dental plans**

Customer Service number: 1-800-440-3619

*Dental claims*
Anthem Dental
P.O. Box 659444
San Antonio, TX 78265

**Online services**
anthem.com (integrated with health online administration)

**Pharmacy claims**

*Express Scripts*
Attn: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872
Fax: 1-608-741-5475

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**Anthem Dental Prime and Complete**

**Employer Services:** 1-877-567-1799

**Customer Service number:** 1-877-567-1806

*Dental claims*
P.O. Box 1115
Minneapolis, MN 55440-1115

**Employer services:** 1-877-567-1799

**Online services**
anthem.com

**Online member services**
anthem.com/mydentalvision
Section 3 — Eligibility

Eligible employees
To be eligible, an employee must be a:

- Full-time employee working at least 30 hours per week and paid by W-2.
- Part-time employee working no less than 15 hours per week. (An employer is not required to offer benefits to part-time employees; however, employers who offer benefits to part-time employees must offer benefits to all part-time employees who meet the same criteria.)

Eligible dependents
To be eligible, a dependent may be:

- The employee’s spouse or the employee’s domestic partner (if you offer domestic partner coverage). For domestic partner criteria, see Affidavit of Domestic Partnership.
- Legally separated or divorced spouse (ex-spouse) may be eligible for coverage if continuation of coverage is elected under federal or state law. As of January 1, 2008, New Hampshire law allows a divorced spouse who is currently covered under the group plan to remain on the subscriber’s plan for a period not to exceed 36 months (Refer to SB197).
- A natural or legally adopted child of the employee, the employee’s spouse or the employee’s domestic partner (if you offer domestic partner coverage), who is under the age of 26 or incapacitated and incapable of self-support due to a mental disorder, developmental disability, mental retardation, or physical handicap.
- A child for whom the employee, the employee’s spouse or the employee’s domestic partner (if you offer domestic partner coverage) is the legal guardian. The child(ren) must qualify as an eligible dependent as defined in your Certificate.
- For health coverage only, child(ren) who the group has determined are covered under a Qualified Medical Child Support Order (QMSCO).

Any child(ren) must be within the age limit and criteria defined in the group Certificate and Schedule of Benefits. Appropriate documentation is needed to confirm legal guardianship.
Open enrollment

Coverage for eligible employees and their dependents who select an Anthem benefit program during a company’s open enrollment period will begin on the designated effective date following the open enrollment period.

Some exceptions may include adding new benefits plans or major changes to employer contribution off anniversary. A Large Group employer may be allowed an election period for currently enrolled members if the employer is introducing or revising a health reimbursement account (HRA) or health savings account (HSA) product off anniversary, subject to Underwriting approval. Underwriting reserves the right to change rates that may be needed due to enrollment changes.

Employer group benefit conversions

Employer groups will be allowed to convert benefits at any time during the year, pending Underwriting and Sales approval. Benefit conversions will result in a change to the employer group’s anniversary date.

New hires

New hires and their dependents will be eligible to enroll following completion of the probationary/waiting period, not to exceed 90 days. Probationary/waiting periods are determined by you upon your group’s initial enrollment and can only be changed at renewal. To verify your group’s probationary/waiting period, please refer to your New Sale Enrollment Agreement/Employer Enrollment Application or contact Sales Support (see page 7 for contact information).

Rehires

Enrolled employees rehired within 30 days of termination will be reinstated without a break in coverage. If rehire occurs within thirteen consecutive weeks after a break in employment, the waiting period will be waived. As part of the ACA Employer Responsibility provision, employers are potentially subject to penalties if they impose waiting periods for employees who have breaks in coverage of less than thirteen weeks.

Some exceptions may apply. Contact your account manager for more information.

If we don’t receive the application on time (within 31 days), the new hire may be considered a late enrollee or late entrant. He or she may only enroll at the group’s next annual/open enrollment.
Special Enrollments (for qualifying events)

If someone who was previously eligible for coverage wants to apply following initial enrollment, he or she may be allowed to enroll during a special enrollment period. The following must be met:

- The employee or dependent declined coverage initially due to other health coverage and:
  - He or she was under COBRA coverage and that coverage has ended.
  - Other coverage ended because of a loss of eligibility or an employer’s ending contributions toward such coverage.
- The individual became a dependent of a certificate holder through marriage, birth, adoption or placement for adoption.

The following is an overview of effective dates as they would apply to special enrollments:

<table>
<thead>
<tr>
<th>Qualifying event</th>
<th>Small Group non-ACA (legacy) plans and Large Group</th>
<th>Small Group ACA-compliant plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of coverage</td>
<td>Date of loss of coverage</td>
<td>Date of loss of coverage</td>
</tr>
<tr>
<td>Marriage</td>
<td>Date of marriage</td>
<td>Date of marriage</td>
</tr>
<tr>
<td>Domestic partnership</td>
<td>Date of affidavit notarization</td>
<td>Date of establishment of domestic partnership</td>
</tr>
<tr>
<td>Divorce</td>
<td>First of month following date of divorce</td>
<td>Date of divorce</td>
</tr>
<tr>
<td>Birth</td>
<td>First of month following date of birth</td>
<td>Date of birth</td>
</tr>
<tr>
<td>Adoption/placement for adoption</td>
<td>Date of placement/adoption</td>
<td>Date of placement/adoption</td>
</tr>
<tr>
<td>Legal guardianship</td>
<td>Date of guardianship order</td>
<td>Date of guardianship order</td>
</tr>
<tr>
<td>Court order</td>
<td>Date as mandated by court order</td>
<td>Date as mandated by court order</td>
</tr>
<tr>
<td>Support order</td>
<td>First of month following receipt</td>
<td>Date of support order</td>
</tr>
<tr>
<td>Death of employee</td>
<td>Date of death</td>
<td>Date of death</td>
</tr>
<tr>
<td>Death of spouse, domestic partner, or dependent</td>
<td>Date of death or first of month following date of death</td>
<td>Date of death</td>
</tr>
</tbody>
</table>
How to enroll an employee and eligible dependents

When an employee and his or her dependents are eligible to apply for membership, they must complete and sign a Member Enrollment Form/Application. They can get the form from you or obtain one online at anthem.com. (See the Section 7 of this guide.)

After an employee has completed the Member Enrollment Form/Application, please make sure the form is accurate and has been signed and dated.

To make sure Member Enrollment Form/Application are processed as quickly as possible:
- Make sure the application is legible. Please type or write clearly and use black ink. For best results, use our fillable PDF Member Enrollment Form/Application available online.
- For managed care plans, make sure the employee has:
  - Chosen a primary care physician (PCP) who participates in the plan’s network and make sure they are accepting new patients (if the employee is a new patient).
  - Checked “yes” or “no” in the Current Patient section.
  - Included the PCP’s full name and provider number (you can search the Provider Directory at anthem.com for current PCP information).
- Make sure all required information is provided, including:
  - Social Security number.
  - Date of birth.
  - Choice of plan.
  - Date of hire.
  - Reason for enrollment.
  - Prior coverage information.
  - Whether or not eligible for Medicare.
  - Address.
  - Sex.
- Submit the Member Enrollment Form/Application on time.

Medicare Secondary Payer (MSP)

Federal law requires insurers and third-party administrators to gather and report information about Medicare recipients who have other group coverage.* This helps the Centers for Medicare & Medicaid Services (CMS) and health insurers coordinate benefit payments so claims can be paid promptly and correctly.

As part of this process, members are asked to provide their Social Security numbers.

*Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), effective January 1, 2009.
Open enrollment (annual enrollment)

We must receive the completed Member Enrollment Form/Application or Member Change Form/Employee Change Form by the last day of the annual/open enrollment month to be effective on the first day of the anniversary month.

New enrollments

Completed Member Enrollment Forms/Applications for new enrollees (new hires or current employees with a qualifying event) must be received within 31 days of the requested effective date.

Enrollment changes (addition or deletion of members)

There may be changes in a member's life that require changes to his or her enrollment. This section explains how members can add a spouse or eligible children to their contract, change their contact information or change a primary care physician. All requested changes must be received within 31 days of the qualifying event (Special Enrollment Period) unless otherwise noted in the group contract. If after 31 days, the application may be resubmitted during the annual/open enrollment period.

On exchange (SHOP) plans are administered through healthcare.gov and are subject to a 30-day Special Enrollment Period.

Marriage

To add a new spouse (and eligible children, if applicable) to the contract, the member needs to complete a Member Change Form/Employee Change Form. The date of marriage must be noted on the application.

Domestic partner (if domestic partnership benefits are offered)

To add a domestic partner (and eligible children, if applicable) to the contract, the member needs to complete a Member Change Form/Employee Change Form, and the Affidavit of Domestic Partnership. The date that the domestic partnership began must be noted on the forms along with a visible notary stamp or seal.

To end the coverage of a domestic partner, the member needs to complete a Member Change Form/Employee Change Form. The member is required to submit the completed Member Change Form/Employee Change Form within 31 days of the termination of the domestic partnership. Domestic partners are not eligible for COBRA continuation coverage.

Birth

To add a newborn dependent to the member’s contract, he or she needs to complete a Member Change Form/Employee Change Form.

Adoption/placement for adoption

To add a newly adopted dependent or a dependent placed for adoption to the member’s contract, he or she needs to complete a Member Change Form/Employee Change Form, and submit with the adoption/placement paperwork.

Court orders and support orders

To add a dependent child due to a court order or a support order, the member needs to complete a Member Change Form/Employee Change Form:

- With a support order for a child, the completed Member Change Form/Employee Change Form must be received within 31 days of the date of the support order.

- With a legal court order changing custody of a dependent child, the completed Member Change Form/Employee Change Form must be received within 31 days of the date of the court order changing custody.

To add a spouse due to a court order of coverage for the spouse, the subscriber needs to complete a Member Change Form/Employee Change Form within 31 days of the date of the court order.
Section 5 — Enrollment procedures

Divorce and legal separation
To delete a divorced or legally separated spouse from the member’s contract, the member needs to complete a Member Change Form/Employee Change Form.

COBRA-eligible dependents who elect to continue coverage within the indicated time frame will be reinstated.

Eligibility for Medicaid or state assistance programs
To delete a spouse, domestic partner or dependent(s) because they have become eligible for Medicaid or other state assistance, the member needs to complete a Member Change Form/Employee Change Form. The spouse and/or dependent(s) are removed from the member’s contract effective on the first of the month following eligibility. Paperwork must be received within 31 days of the requested cancel date. If the request is received late, the member will be canceled on the first of the month following receipt unless otherwise noted in the group contract.

Eligibility for Medicare
Three months before a member’s 65th birthday, we will mail you a Notice of Medicare Eligibility form. Please be sure to complete and submit this form as requested. When an employee or an employee’s spouse or dependent becomes eligible for Medicare due to age, disability or end-stage renal disease (ESRD), inform us immediately by submitting the proper paperwork (Notice of Membership Change Form/Employee Change Form and/or Member Enrollment Form/Application). Federal law determines the primary payer of benefits for these individuals:

- For groups with 2-19 full-time and part-time employees
  In general, Medicare is the primary payer. Employer group benefits are secondary for employees and employees’ spouses aged 65 and over. Employers can choose to offer a group Medicare Supplement Plan to Medicare eligible individuals. To qualify, eligible individuals must enroll in Parts A and B of Medicare. Any individual considering a delay in Medicare enrollment should be directed to the nearest Social Security Administration office for immediate guidance.

  Because Medicare Supplemental Plans are administered when employees become Medicare eligible, and elect a Medicare Supplemental Plan, the previous membership type will need to be changed, for example, from “Applicant/Spouse” to “Individual.”

- For groups with 20 or more full-time and part-time employees
  In general, Medicare is the secondary payer for active employees and their spouses who are 65 or older. Federal law requires such employers to offer active full-time employees and their spouses 65 and older the same health benefits as those under 65, and under the same conditions. If the employee cancels coverage and elects Medicare, you, as the employer cannot provide a Medicare Supplement Plan, but the employee can purchase one on his or her own from Anthem.

Some Medicare eligibility exceptions apply. Please see page 32 for more information.

Consult your attorney for more information on how these laws affect your group.

Termination of employment/reduction in hours
To delete a member whose employment has been terminated or hours reduced, please complete a Notice of Membership Change Form/Employee Change Form indicating the date of termination/change.

COBRA-eligible employees who elect to continue coverage within the indicated time frame will be reinstated.

Death of an employee
To delete a deceased member, please complete a Notice of Membership Change Form/Employee Change Form indicating the date of death and submit within one year. Premiums will be pro-rated, unless otherwise noted in the group’s contract.

Death of a spouse or dependent
To delete a deceased spouse, domestic partner or dependent from the member’s contract, the member needs to complete a Member Change Form/Employee Change Form.
Section 5 — Enrollment procedures

Removal of a dependent
To delete a spouse, domestic partner or dependent(s) from coverage, the member needs to complete a Member Change Form/Employee Change Form.

COBRA-eligible dependents who elect to continue coverage within the indicated time frame will be reinstated.

Termination Continuation of Coverage
To delete a member who is no longer eligible for continuation of coverage, please complete a Notice of Membership Change Form/Employee Change Form.

To delete a member who elects to voluntarily cancel continuation of coverage, the member needs to complete a Member Change Form/Employee Change Form.

Involuntary loss of existing coverage (portability)
Portability is the transfer of membership when previous coverage ends involuntarily. Portability applies for reasons such as:

- Termination of employment.
- Termination (without replacement) of the group contract or policy.
- Divorce/legal separation.
- Termination of domestic partnership.
- Exhaustion of COBRA benefits.
- Death.

To add a spouse, domestic partner or eligible dependent(s) due to a portability event, the member needs to complete a Member Change Form/Employee Change Form.

If we receive the completed form:

- Within 60 days of the loss of group coverage, coverage will be effective on the date of loss of coverage, unless otherwise noted in the group’s contract.
- After 60 days from the loss of group coverage, the Member Change Form/Employee Change Form may be submitted during the annual/open enrollment period or considered a late entrant and subject to penalty depending upon type of coverage selected.

The member needs to write the name of the previous insurance carrier, contract number, the date and reason for the loss of coverage on the Member Change Form/Employee Change Form. We may contact the previous carrier to verify loss of coverage.

Involuntary loss of Medicaid or state assistance programs
To add a spouse, domestic partner or dependent(s) because he or she involuntarily lost Medicaid/Medicare or other state assistance coverage, the member needs to complete a Member Change Form/Employee Change Form. The member should include a copy of the letter from Medicaid or the applicable state assistance program that states the date Medicaid or state assistance program coverage ended, and the reason for the loss.

If we receive the Member Change Form/Employee Change Form, to add a spouse or dependent(s) who involuntarily lost Medicaid or other state assistance coverage:

- Within 31 days from the loss of assistance, coverage is effective on the first of the month following the loss of assistance, unless otherwise noted in the group’s contract. A copy of the letter stating that coverage has ended, the reason coverage ended, and the effective date of the loss must accompany the Member Change Form/Employee Change Form.
- After 31 days from the loss of assistance, the Member Change Form/Employee Change Form and Family Health Statement, if applicable, may be submitted during the annual/open enrollment period. A copy of the letter stating that coverage has ended, the reason coverage ended, and the effective date of the loss must accompany the Member Change Form/Employee Change Form.
Entrance to or discharge from military service
To add a spouse, domestic partner or dependent because of discharge from the military, the member needs to complete a Member Change Form/Employee Change Form.

If we receive the Member Change Form/Employee Change Form:
- Within 31 days of the date of discharge, coverage is effective on the day following the date of discharge.
- After 31 days from the date of discharge, the Member Change Form/Employee Change Form may be submitted during the annual/open enrollment period.

To cancel coverage, or to delete a spouse, domestic partner or dependent due to entrance in the military service, the member needs to complete a Member Change Form/Employee Change Form. The coverage will be canceled as of the effective date of the military coverage if we are notified within 31 days of the effective date of the military coverage.

Retiree benefits
Please refer to your plan documents or contact your account service team for information about benefits available for retirees.

Changing contact information
A member needs to notify us of the following:
- Name changes
- Address changes
- Telephone number changes (both work and home)

One way to notify us is by submitting a Member Change Form/Employee Change Form. A member can also call the Customer Service number on his or her ID card or make the change online at anthem.com.

Explanations of benefits (EOB) and other correspondence are mailed to the address we have on file. It is important that they are up-to-date.

Correcting dates of birth
The member needs to complete a Member Change Form/Employee Change Form to correct date of birth errors. Members should let us know about birth date corrections as soon as possible to avoid inconsistencies in membership records. We may require a copy of the birth certificate for verification.

Changing primary care physicians
Members can change primary care physicians (PCP) at any time. To notify us, members can:
- Fill out a Member Change Form/Employee Change Form. PCP changes will be effective on the first of the month following receipt of the Member Change Form/Employee Change Form.
- Call our Customer Service representatives. PCP changes made by phone will be effective immediately.
Moving out of the service area

If a member of a managed care product (HMO) moves out of the service area, he or she must transfer to another type of health plan. If you do not currently offer an alternate plan option that would provide adequate coverage, you can add a plan by contacting your account manager or sales support. See page 6 for contact information.

Members moving inside the service area does not constitute a qualifying event to change plans. They will need to wait until your next annual open enrollment period to change plans.

Flexible benefits plans (Section 125 plans)

The Internal Revenue Code Section 125 allows employers to offer their employees flexible benefits plans. The three types of plans are:

- Premium-only plans or premium conversion plans: Permits employees to pay the employee contributions to employer-provided health and welfare benefit plans on a pretax basis.
- Flexible spending accounts and flexible reimbursement accounts: Reimburses employees on a tax-free basis for eligible child care and health care expenses that are not otherwise covered by the employer-sponsored benefit plan.
- Cafeteria plans: Allows employees to choose between certain nontaxable benefits and cash.

Section 125 of the Internal Revenue Code and regulations define situations when an employee can make off-anniversary changes. Situations when employees can make flexible benefits election changes do not always entitle the subscriber to make a related change to his or her health coverage. For example, the birth of a child entitles the subscriber to enroll the child and spouse in the health plan and change the flexible reimbursement account, but not to enroll other dependents in the health plan or to change their coverage series/benefits. Those changes can only be done at the group’s annual/open enrollment period. A Section 125 plan does not create enrollment opportunities that do not exist without a 125 plan. Work with your Section 125 processor if you have any questions.

Special enrollment considerations

Additional forms are required for:

- **Dependent child, incapacitated, incapable of self-support:** a Request for Coverage for a Mentally or Physically Incapacitated Dependent Child form
- **An adopted child:** proof of adoption or placement
- **Medicare eligible:** a copy of the Medicare health insurance card
- **Adding a child, court order:** a copy of the court order
Electronic enrollment advantages

Electronic enrollment is a quicker, easier way to maintain enrollment-related data and manage the enrollment process.

- **Time saving**: Electronic enrollment is a faster, more convenient way to enroll new members and make changes to existing accounts 24/7. It eliminates paperwork, reduces postage and may require fewer follow-up phone calls. Best of all, the information is processed on an average of two to four days faster than paper forms.

- **Safe, secure, accurate**: To help protect against unauthorized access to employees’ private information, electronic enrollment is enhanced with the latest security technology. In addition, employees receive a user ID and password that can be personalized during the registration process.

For more information about electronic enrollment, contact your Anthem account manager.

Electronic enrollment options

<table>
<thead>
<tr>
<th>Description</th>
<th>Web-based enrollment</th>
<th>File-based transfer for Large Group employers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Web-based enrollment</strong></td>
<td>The same process as on paper, but online. Complete enrollment applications through online forms.</td>
<td>Ideal for high volumes of enrollment transactions when a group prefers to send an enrollment file.</td>
</tr>
<tr>
<td><strong>Platform</strong></td>
<td>Web-based, accessed through a browser</td>
<td>Site-specific, PC-based, Mainframe</td>
</tr>
<tr>
<td><strong>Allows enrollment by Benefit Administrator</strong></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Allows enrollment by employees</strong></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Features**

- New employee enrollment
- Open enrollment management
- Membership maintenance (add, change, delete)
- 128-bit encryption for safe, secure transfer of information
- 24/7 access
- Automated member setup
- 2 to 4 days faster processing than paper forms, on average
- Quicker ID turnaround and member benefit realization

- New employee enrollment
- Open enrollment management
- Membership maintenance (add, change, delete)
- Secure
- 24/7 access
- Quicker ID turnaround and member benefit realization

Groups should review the file-based legal agreement to evaluate its advantages and disadvantages.
Online tools and resources for employers

With our secure online business tools, it’s easier to manage your benefit package.

Employer Group Inquiry (EGI) for Small Group non-ACA (legacy) plans and Large Group

Through the EGI feature, you can efficiently manage day-to-day benefit administration tasks:
- View contract and coverage information, such as current address, phone number, contract number, plan details and more.
- View benefit details, such as copays and deductibles.
- Update primary care physician, if applicable.
- Request replacement ID cards.
- Update member contract information, such as address and phone number changes.
- View employee coverage choices from previous years.

Web enrollment for Small Group non-ACA (legacy) plans and Large Group

Web enrollment helps reduce excess paperwork, so that you can focus on your core business. This secure, password-protected application lets you:
- Enroll new employees.
- Perform enrollment maintenance.
- Add or cancel dependents.
- Cancel contracts.
- Update names and addresses.
- Perform self-service tasks for open or new group enrollments.
- Reinstate contracts.*

* Subject to Anthem Blue Cross and Blue Shield’s underwriting guidelines and requires Anthem Blue Cross and Blue Shield’s consent.

EmployerAccess for Small Group ACA-compliant plans

EmployerAccess is a secure application that allows you to more efficiently administer your ACA-compliant plan. EmployerAccess includes all the benefits of Web enrollment, plus:
- Intuitive navigation.
- New functionality and tools.
- Integrated benefits management.
- Ability to view and pay premium bills online.

Online Group Billing (Available through Employer Group Inquiry and EmployerAccess)

Online Group Billing allows you to view and pay your bills online. This easy and convenient tool lets you:
- View and print detailed premium bills going back 13 months:
- Pay bills electronically in a secure online environment.
- Manage your bank accounts with privacy.
- Eliminate paper bills completely (optional).

File-based transfer

File-based transfer is a process that’s ideal for larger groups. It’s secure and can be used to perform the same eligibility functions as Web enrollment.

Contact sales support or your account manager for more information regarding these options.

Online tools and resources for members

Instant access to our online tools makes it easier for employees to perform a variety of self-service functions, so you can focus on your daily business. The more your employees know about their plan, the better they can use it to their advantage. Employees have access to programs and services designed to help them get the most from their benefits.

Anthem.com

The vast amount of health information available at anthem.com gives your employees the tools they need to help them make health care decisions. Safe and secure, members can log in and:
- View benefit details, including copayments and deductibles.
- Check claims status.
- Choose a new primary care physician, if applicable.
- Find a network doctor or hospital.
- Request a permanent or temporary member ID card.
- Change passwords.
- Update an email address.
- Sign up for email messages from Anthem Blue Cross and Blue Shield.
- Submit benefit questions to Customer Service.

Anthem’s Mobile App

Members can download Anthem’s mobile app from Google Play™ (Android) or the Apple Store™ (iOS). With the app, members can:
- Find a Doctor: Search for a doctor, specialist, urgent care or hospital close by. The app even gives turn-by-turn directions to get them there.
- Use fingerprint touch ID: One touch of a finger logs members right into the app.
- View ID cards: If a member forgets his or her ID card, no problem! They can have an exact replica of their card right on their phone through the app.
- Access their Mobile Health Record: Members can view their Health Record and share with their doctors anytime.
- Submit benefit questions to Customer Service through our secure message center.
Below is a list of the commonly used forms available on anthem.com.

<table>
<thead>
<tr>
<th>Form type</th>
<th>For Small Group non-ACA (legacy) plans and Large Group</th>
<th>For Small Group ACA-compliant plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>New group enrollment</td>
<td>New Sale Enrollment agreement</td>
<td>Off-Exchange Employer Enrollment Application</td>
</tr>
<tr>
<td>New member enrollments</td>
<td>Member Enrollment/Member Change Form</td>
<td>Off-Exchange Employee Enrollment Form</td>
</tr>
<tr>
<td>Membership changes</td>
<td>Member Enrollment/Member Change Form</td>
<td>Off-Exchange Employee Change Form</td>
</tr>
<tr>
<td>(adding/removing dependents, etc.)</td>
<td>Member Enrollment/Member Change Form</td>
<td></td>
</tr>
<tr>
<td>Renewal changes</td>
<td>N/A</td>
<td>Group Demographic Change and Benefit Plan Change Authorization form</td>
</tr>
<tr>
<td>Membership terminations</td>
<td>Notice of Membership Change Form</td>
<td>Employee Change Form</td>
</tr>
<tr>
<td>Submission information</td>
<td>Fax to 1-877-651-7949</td>
<td>Fax to 1-855-750-2227</td>
</tr>
</tbody>
</table>

New group paperwork, including the employer and member applications, should be submitted to Sales Support for review and processing. See page 6 for contact information.

Questions? Call our Sales Support Call Center at 1-800-250-5420.
Section 8 — Claim filing

**Hospital claims**

When a member enters a participating hospital as either an inpatient or outpatient, the member should present his or her Anthem ID card to the admitting office. The hospital will bill Anthem automatically for services rendered, less any applicable cost shares.

When covered, if a member receives inpatient services in a nonparticipating hospital, the member should request that the hospital bill Anthem directly. Otherwise, the member may have to pay the bill and forward a receipt and itemized copy of the bill to Anthem, along with a completed claim form.

When covered, if a member receives outpatient services at a nonparticipating hospital, the member may have to pay the bill at that time. If this is the case, the member should forward a receipt and an itemized copy of the bill to Anthem with a completed claim form. Members should send this information to:

Anthem Blue Cross and Blue Shield  
P.O. Box 533  
North Haven, CT 06473

Please remember that when members incur charges from a nonparticipating provider and are required to submit a claim, each member needs to submit a separate claim.

Members can obtain a claim form at anthem.com or they can call the toll-free Customer Service phone number on the back of their member ID card.

**Medical/surgical claims**

Members should present their Anthem ID card and pay any applicable copays at the time services are rendered. Participating providers will bill Anthem directly for services and will bill members separately for any noncovered services. The member is responsible for any cost shares per the benefit plans.

After we process the claim, the provider will receive a remittance explanation and payment. As part of the participating agreement, the provider agrees not to bill the member for any balances beyond our allowed amounts for covered services.

When covered, if services are rendered by nonparticipating providers, the member may be required to submit a claim form. If this is the case, the member should complete the form and include an itemized bill containing the name and address of the provider, nature of the condition requiring treatment, date of service, explanation of services provided and the charge for each service. The member should also keep a copy for record keeping purposes. The member should send this information to:

Anthem Blue Cross and Blue Shield  
P.O. Box 533  
North Haven, CT 06473

Members can obtain a claim form at anthem.com or they can call the toll-free Customer Service phone number on their member ID card.

Members will receive an *Explanation of Benefits* (EOB) only when there is a patient balance for the claim (other than a copay). Members may be charged amounts beyond what we allow for nonparticipating providers.
BlueCard: The out-of-area program

To locate participating out-of-area providers, members can call the BlueCard® Access Line at 1-800-810-BLUE (2583). When a plan allows for out-of-network benefits, if members visit health care providers (institutional or professional) located outside New Hampshire, they should present their Anthem ID card when services are rendered. The three-letter prefix on the ID card identifies Anthem as the home plan — the destination of all provider claims. Providers must include this prefix on the claim form to expedite claims processing.

In the event of urgent or emergency care needs, a member can seek the services of an out-of-area provider who will submit the claim on behalf of the member to the local Blue Cross and Blue Shield plan for processing, as long as the provider is participating with the Blue Cross and Blue Shield plan in that area. The member is responsible at the time of service for any applicable copay, coinsurance or deductible. Participating out-of-area providers may not balance bill members.

BlueCard Worldwide program

When members receive services from a BlueCard Worldwide participating provider for inpatient services rendered out of country, the provider should submit the claim on the member’s behalf.

For services rendered out of country for outpatient and professional urgent or emergency medical care by a nonparticipating BlueCard Worldwide hospital or when inpatient care was not arranged through the BlueCard Worldwide Service Center, the member will need to pay any charges up front and submit an International Claim Form for possible reimbursement.

The Blue Card Worldwide International Claim Form can be found at bcbs.com:

- In the Search window, enter the words claim form.
- Select Blue Card International Claim Form.

This form, along with any itemized bills, should be sent to the following address for processing. Itemized bills do not have to be translated into English or dollars.

BlueCard Worldwide Service Center
P.O. Box 261630
Miami, FL 33126
USA
claims@bluecardworldwide.com

Please make a copy of the claim and related information (such as a breakdown of charges and receipts) before submission.

Anthem Dental

When a member receives dental care from a participating dentist, he or she should present the member ID card at the time services are offered. The dentist will bill us for services. Payment for covered services, as provided in the policy, will be made directly to the dentist.

When a member receives dental care from a nonparticipating dentist, a dental claim form or an American Dental Association (ADA) claim form must be completed. Members should send completed dental claim forms signed by the dentist to the claims address on the back of their member ID card.

If claim forms are not available at the dentist’s office, members can obtain them at anthem.com or they can contact the Customer Service department at the toll-free phone number on the back of their member ID cards. Payment for covered services will be made directly to the dentist. If a member is submitting a claim for services with a nonparticipating dentist, the members can choose to have payment sent directly to them.
Prescription drug claims
Members purchasing prescription drugs from a participating pharmacy should present their member ID card and pay any applicable copay at the time the prescription is filled. The pharmacy will bill Anthem. Payment for covered services, as provided in the policy, will be made directly to the pharmacy.
When prescriptions are purchased at a nonparticipating pharmacy, the member must submit the claim to us. Members should use a prescription drug claim envelope and enclose the original itemized prescription receipts containing:
- Patient’s name and member identification number
- Pharmacy name
- Prescription number
- Date of purchase
- Name and quantity of the drug
- Amount paid
Payment for covered services, as provided in the policy, will be made directly to the member.
Photocopies of prescription drug receipts will not be accepted for processing.

Home delivery prescription
To start receiving prescriptions through the mail, members placing an order for a prescription they are currently taking should:
1. Have their prescription information, doctor’s name and phone number, and credit card (Visa, MasterCard or Discover).
2. Contact Express Scripts at:
   - 1-888-613-6091
   - 1-800-899-2114 (hearing impaired)
Quick reference guide

Use this checklist to help administer your Anthem plan:

☐ Submit enrollments, changes and terminations
   Please submit all enrollments, changes and terminations as they occur. See page 21 for submission and deadline information.
   Do not include member enrollments, changes or terminations with your payment.

☐ Check your bill
   When you receive your invoice, please verify the following information:
   - Bill creation date: The date this invoice was prepared for you.
   - Payment due date: The date your payment is due at Anthem.
   - Current period: The period covered by the invoice.
   - Premium amount billed: This month’s premium due for the invoice.
   - Total amount due for current and prior periods: Total premium due for service.

☐ Verify employee changes:
   - Bill creation date: The date this invoice was prepared for you. If you mailed your changes in after the invoice was created, you will see them on next month’s invoice. Please pay as billed.
   - Member detail: Verify names, type of change, product name, class of contract, effective date of change and amount for all applications submitted.

☐ Check how much is due:
   - Total amount due for current and prior periods: Total premium due for service.
   - Amount due for current period: Current period amount due including any retroactive charges.
   - Total amount due last invoice: Total premium billed for prior invoice.
   - Net payment activity since last invoice: Premium received since the last invoice.
   - Balance carried forward: Outstanding premium from the prior invoice.

☐ Pay the invoice as billed
   Be sure to detach the bottom portion of the invoice summary and enclose it with your check in the return envelope.
Need assistance?

For Small Group non-ACA (legacy) plans and Large Group, please contact the Billing Call Center at 1-800-273-2521.

For Small Group ACA-compliant plans, contact our dedicated team at 1-855-250-7763.

Reminder

Please remember that all monthly premium payments are due on the first of the month of coverage. Failure to remit your premium payment in a timely manner will result in cancellation of your account for nonpayment.

When you receive your monthly invoice, please remember to pay the invoice as billed and include the invoice coupon with your payment. Please do not send enrollments or changes with your payment. All additions or cancellations should be submitted separately and will be reflected on your next scheduled invoice.

Return check fee:

- A $25 fee will be assessed for any returned checks.
- The $25 returned check fee must also be paid by the subsequent invoice to avoid termination.

Commitment to service

As part of our commitment to improve the service we provide, premium payments will be processed at a separate location from membership correspondence. To ensure proper processing of monthly premium payments, please mail them in the return envelope enclosed with your bill. Premium payments can also be made electronically with Online Group Billing.

Important: Please use this lockbox address information for premium payments:

For Small Group ACA-compliant plans:

Anthem Blue Cross and Blue Shield
P.O. Box 11792
Newark, NJ 07101-4792

For Small Group non-ACA (legacy) plans and Large Group:

Anthem Blue Cross and Blue Shield
P.O. Box 1168
Newark, NJ 07101-1168

Membership status changes or correspondence should be submitted separately via fax to:

1-877-651-7949 for Small Group non-ACA (legacy) plans and Large Group
1-855-750-2227 for Small Group ACA-compliant plans
# Glossary of invoice terms

<table>
<thead>
<tr>
<th>Message</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Addition</strong></td>
<td>Employee (member) has been added.</td>
</tr>
<tr>
<td></td>
<td>Employee (spouse) has been changed to a Medicare Supplemental Part A or B.</td>
</tr>
<tr>
<td></td>
<td>Employee (member) has been added to a COBRA eligibility extension group division.</td>
</tr>
<tr>
<td>Add dependent</td>
<td>Employee (member) has added dependent(s).</td>
</tr>
<tr>
<td><strong>Cancel</strong></td>
<td>Employee (member) has been canceled.</td>
</tr>
<tr>
<td>Cancel dependent</td>
<td>Employee (member) has been canceled as a result of reaching the maximum age allowed for dependent coverage.</td>
</tr>
<tr>
<td></td>
<td>Employee (member) has canceled dependent(s).</td>
</tr>
<tr>
<td>Name change</td>
<td>A change in name has been processed for an employee (member).</td>
</tr>
<tr>
<td>Transfer in</td>
<td>Employee (member) has been transferred into a health plan at your request.</td>
</tr>
<tr>
<td>Transfer out</td>
<td>Employee (member) has been transferred out of a health plan at your request.</td>
</tr>
<tr>
<td>Product conversion add</td>
<td>Employee (member) has been added to a health plan due to a product conversion.</td>
</tr>
<tr>
<td>Product conversion cancel</td>
<td>Employee (member) has been canceled from a health plan due to a product conversion.</td>
</tr>
<tr>
<td>Reinstatement</td>
<td>Employee (member) has been re-added with no break in coverage.</td>
</tr>
<tr>
<td>Reattach</td>
<td>Reattach employee (member) with a break in coverage.</td>
</tr>
</tbody>
</table>
Section 10 — Accounting and terminations

This section explains your invoice, payment requirements, how to adjust your bill, how to terminate employee/member health care coverage and the conversion privileges available to terminated employees.

Payment

Premium payments are due by the date shown on your group invoice. Make your group’s check payable to Anthem Blue Cross and Blue Shield, write your billing account number on the check and send it with the bottom section (the invoice coupon) of the bill to:

Anthem Blue Cross and Blue Shield
P.O. Box 1168
Newark, NJ 07101-1168

Note: For Small Group ACA-compliant plans, please remit payment to:

Anthem Blue Cross and Blue Shield
P.O. Box 11792
Newark, NJ 07101-4792

Expedited payment:

For Small Group non-ACA (legacy) plans and Large Group, payment can be overnighted to:

Anthem Blue Cross and Blue Shield
WPT ACES 4168
365 W. Passaic St. Suite 530, 5th Floor
Rochelle Park, NJ 07662

For Small Group ACA-compliant plans, to expedite payment, you can:

- Pay online.
- Pay by phone at 1-855-886-6158.

Pay online

You also can use our Online Group Billing option. See page 18 for details.

Our invoices are normally mailed between the 10th and 20th day of the month prior to the due date. Premium payments are due on the first of each month.

If payment is not received by the due date, your group is considered delinquent. We will send a letter informing you that payment is past due and that group coverage may be canceled if we do not receive full payment by the date specified in the letter. (If we are responsible for the delay in sending the bills, you will not receive a delinquency notice.)

If we do not receive payment by the date specified in the letter, coverage will end 31 days after the premium or fee due date. A cancellation notice is mailed to the group and its members.

If your group is not paid to date, member enrollments will not be processed.

If your group has an alternative financial arrangement, different policies may apply. Contact your Account Service team for information.
Reinstatement

A group may request reinstatement following cancellation of group coverage according to the process listed below:

- All past due premiums and any current premiums must be paid in full.
- A $150 reinstatement fee must also be paid at the time of request.
- We will review the group’s financial status, including reviewing the group’s payment history or any other information, and may request a Dunn and Bradstreet report, credit references or a bank letter.
- The request for reinstatement must be made within 30 days of cancellation. After 30 days, a group must contact their agent/producer or Sales account executive to request enrollment as a new group.

NOTE: Effective November 1, 2016, Small Group plans that terminate for nonpayment of premium and wish to reinstate with no break in coverage, must sign up for reoccurring payments in order to reinstate. Exceptions must be approved by the Accounts Receivable Manager.

Retroactive coverage changes

Anthem’s standard policy is to allow retroactive additions and cancellations of no more than 60 days regardless of claims activity. Anthem reserves the right to recover any claim dollars incurred in the 60-day retroactive term period.

We require that groups notify us promptly if a member becomes ineligible for coverage. If a group provides a cancellation request to us within 60 calendar days of the date that coverage should have ended, we will process the request and allow the cancellation to become effective as of the date that coverage should have ended.

Requests for retroactive additions to member and dependent coverage beyond 60 days will be processed as late entrants and will follow the late entrant enrollment policy.

On a case-by-case basis, special consideration will be given to requests for retroactive coverage changes under the following limited circumstances:

Retroactive terminations:

- **Death:** Terminations as a result of death will be allowed up to one year upon receipt of a copy of the death certificate.
- **Retirement over 65:** Terminations allowed for a period of up to six months back to the effective date of Medicare A&B upon receipt of a copy of the Medicare card.

Retroactive Additions:

**COBRA:** Additions allowed for 60 days.

It is important to note that where Anthem is responsible for a documented membership processing error, and for up to a period of six months following the original request, we will promptly process the change as originally submitted.

This policy applies to both fully insured and self-insured groups. Groups using a Third-Party Administrator (TPA) also follow the same guidelines listed above.
Federal law may have a direct impact on your group’s health benefits. Please read the following information carefully. This is a general guide on these laws, but it is not to be considered legal advice. Please ask your group’s legal counsel any questions you have about compliance with these laws. There are substantial penalties for noncompliance with these federal laws, and these penalties apply to the employer. You are required to indicate whether or not OBRA (group size 100 or more) and COBRA (group size over 20) apply to your group when you apply for coverage. You are also required to promptly notify us in the event that your status changes.

**NH State Continuation of Coverage Law (NH C of C)**
This law was established by New Hampshire legislation to provide continuing group health coverage for those whose coverage would otherwise be terminated.

For more information about NH C of C, contact the New Hampshire Insurance Department at 1-603-271-2261 or visit nh.gov/insurance.

**Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)**
COBRA was established to provide continuing group health care coverage for those whose coverage would otherwise be terminated.

This law applies to group health plans maintained by employers with **20 or more employees** as long as the employers are in the private sector, state or local government.

For more information about COBRA, contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit dol.gov/ebsa.

**Omnibus Budget Reconciliation Act of 1986 (OBRA)**
OBRA legislation has two parts. One part concerns continuation for retirees, their spouses and dependents of an employer who files for protection under Chapter 11 of the Federal Bankruptcy Act. The other concerns Medicare eligibility for individuals under age 65.

It applies to most New Hampshire employers with 100 or more full- and part-time employees. Certain employers are exempt from OBRA, such as religious entities.

For more information about OBRA contact:
U.S. Department of Labor
Pension and Welfare Benefits Administration
Division of Technical Assistance and Inquiries
200 Constitution Ave., NW, Room N-5658
Washington, DC 20210
Administrative information on COBRA, NH C of C and OBRA

For NH Continuation of Coverage (NH C of C), COBRA and OBRA, coverage begins on the day after group coverage would otherwise end. When an employee leaves, or a dependent becomes ineligible for membership it is very important that you send the necessary paperwork to notify Anthem to cancel coverage and remove the employee and/or any dependents from your premium billing. Anthem must receive your paperwork within 60 days of the event date. Qualified beneficiaries have up to 45 days under NH C of C, and up to 60 days under COBRA and OBRA, after the date of their notification to decide whether or not to elect to continue coverage.

If prior to the end of the decision period, an employee or dependent elects to exercise his or her right to have coverage continued, he or she will be added back on the plan retroactively to the date of termination (understanding that arrangements have been made between you and the former employee for premium owed). The employee must first fill out a new application.

When you and your legal counsel have determined that an individual is no longer eligible to continue coverage, or if the member voluntarily cancels the continuation policy, you must notify Anthem to cancel coverage as outlined in Section 5 of this guide.

If continuation of coverage ends, the continuing member may be eligible to convert to a nongroup Anthem policy. The member must have been covered under the group plan for at least 60 days and must apply for nongroup coverage within 31 days after termination from group coverage.

Medicare

Medicare is a federal health insurance program consisting of three health care program components:

- Medicare Part A (hospital benefit) covers usual expenses in hospitals and skilled nursing facilities, and approved home health care expenses.
- Medicare Part B (physician benefit) helps pay for doctors’ services and medical items and services not covered under the hospital insurance program.
- Medicare Part D helps pay for prescription costs.

Medicare Supplement Programs are intended to fill the gaps in benefit coverage not satisfied by Medicare. Medicare Supplementary coverage for individuals eligible for Medicare will vary, depending on the coverage option elected by the employer. The employer should make available supplementary coverage for individuals who have Medicare as their primary plan.

Carve-out is available for employers who do not offer a Medicare Supplement Program, who have Medicare-eligible employees actively at work, and who continue to provide group coverage to those employees. Carve-out is a process to coordinate benefits with Medicare under Federal Medicare Secondary Payer guidelines.

Medicare Secondary Payer (MSP) regulations

The following chart contains general guidelines for determining primary coverage given your group’s size, the active employees’ or dependents’ status and Medicare qualifying event. To define “active” employment for your group, seek legal counsel.

If you have a question on determining primary coverage, contact the Centers for Medicare and Medicaid Services (CMS) at cms.gov.
### Medicare and group coverage: Who is the primary carrier?

#### Actively at work:

<table>
<thead>
<tr>
<th>Medicare eligible</th>
<th>Medicare enrolled</th>
<th>Groups 19 or fewer employees</th>
<th>Groups 20-99 employees</th>
<th>Groups 100 or more employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member is 65 or over and Medicare eligible due to age</td>
<td>Part A</td>
<td>Medicare coverage is primary</td>
<td>Group coverage is primary</td>
<td>Group coverage is primary</td>
</tr>
<tr>
<td></td>
<td>Parts A &amp; B</td>
<td>Medicare coverage is primary (employee elects the Group Medicare Supplemental policy)</td>
<td>Group coverage is primary Employee may select:</td>
<td>Same requirements as in Groups of 20 or more</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>○ Group coverage as primary, or</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>○ Medicare as primary. If this option is chosen, the beneficiary is NOT eligible for group coverage. The employee may purchase a non-group supplement policy at his or her own expense. The group cannot contribute to the nongroup policy.</td>
<td></td>
</tr>
<tr>
<td>Member is under 65 and Medicare eligible due to disability</td>
<td>Parts A</td>
<td>Medicare coverage is primary</td>
<td>Medicare coverage is primary</td>
<td>Group coverage is primary</td>
</tr>
<tr>
<td></td>
<td>Parts A &amp; B</td>
<td>Medicare coverage is primary*</td>
<td>Medicare coverage is primary*</td>
<td>Group coverage is primary</td>
</tr>
<tr>
<td>Member has ESRD</td>
<td>Member has Medicare coverage for end-stage renal disease (ESRD)</td>
<td>For all group health plans, group coverage is primary during the first 30 months of Medicare eligibility if the member has Medicare solely due to ESRD. (Medicare becomes primary when the 30-month coordination period ends.)</td>
<td>Exception: If a member already has Medicare primary due to age or disability (see above) and then he or she also becomes an ESRD beneficiary, Medicare remains primary. There is no 30-month coordination period.</td>
<td></td>
</tr>
</tbody>
</table>

* Complete a Medicare Supplemental Selection Form and return to Anthem.
Employee must have both Parts A & B of Medicare to be eligible for the Group Medicomp policy.
Section 11 — State and federal law

Not actively at work:

For Anthem groups of two or more: Retiree plans may be made available to former employees at the option of the employer and subject to Anthem underwriting guidelines:

- **When Medicare is primary:** Medicare is primary for most “not actively at work” employees, such as retirees, employees covered on an employer’s disability segment for more than six months.

- **Exception for ESRD:** If an employee had Medicare as secondary due to age or disability immediately before he or she also becomes an ESRD beneficiary, Medicare remains secondary throughout a 30-month coordination period, even if the employee becomes a “not actively at work” employee covered under retiree or disability. When the 30-month coordination period ends, Medicare becomes primary.

- **How Medicare works with COBRA:** Under federal COBRA law, an employee may continue on COBRA if he or she also has Medicare, provided that he or she was entitled to Medicare on the day of COBRA election. Medicare is prime with one exception for ESRD (stated above). If Medicare entitlement occurs after COBRA election, COBRA coverage may end if the group’s plan documents so designate. (Entitlement to Medicare means that the member is actually enrolled in Medicare.)

If your employee is on COBRA continuation, please refer to the COBRA regulations for MSP rules.

The information provided here does not constitute legal advice. Please contact your attorney if you have any questions regarding the application of state and federal laws to your employee benefit plan.

**Employer obligations**

It is your obligation to ensure that beneficiaries who are covered by the MSP statute are not improperly enrolled in carve-out or Medigap coverage under your plan. If an individual is improperly enrolled in a supplemental or secondary policy or contract when the individual should be enrolled in a plan that makes the group health plan (GHP) the primary payer, it is Medicare’s position that Medicare pays secondary and the plan is required to pay primary regardless of contrary language contained in the plan or contract. Individuals may choose to purchase and pay for Medigap insurance on their own, but neither the employer nor the GHP may sponsor, contribute to or finance such coverage.

**Dual Medicare eligibility**

Some people can qualify for Medicare for more than one reason. Special rules apply in this instance. If one of your employees or his or her dependents qualifies for Medicare for more than one reason, you may contact your account executive or contact CMS to find out whether your GHP or Medicare will be the primary payer.

**TEFRA/DEFRA**

Tax Equity and Fiscal Responsibility Act of 1982 and Deficit Reduction Act of 1984. Companies who sponsor group health plans (including tax exempt and government entities) with 20 or more employees in each of 20 or more weeks in the current or preceding year must comply with TEFRA/DEFRA. The definition of employee includes full- and part-time employees and self-employed people such as consultants, business owners, directors and clergy. TEFRA/DEFRA requires employers to offer currently employed workers and their spouses who are age 65 and older the same health care coverage offered to younger workers. The employee can elect Medicare as either the primary or secondary coverage. If the employee chooses to stay on the group plan, the Medicare coverage is secondary to the employer-sponsored plan. The employee or spouse can reject the employer-sponsored coverage in writing, be removed from group coverage, choose Medicare as the primary payer, and purchase Medigap coverage at his or her own expense.
Family Medical Leave Act (FMLA)

This law entitles employees who have been employed for at least 12 months by the same employer, and have worked 1,250 or more hours during the 12-month period immediately preceding the start of the leave to take a total of 12 work weeks of leave during any 12-month period if one or more of the following occurs:

- Birth or adoption of a child
- Placement with employee of a child for adoption or foster care
- Care for spouse, son, daughter or parent who has serious health condition
- Serious health condition of the employee

The law applies to employers with 50 or more employees, including those employers with multiple locations within a 75-mile radius of each other whose total employee count equals 50 or more.

An employee is entitled to a total of 12 weeks of unpaid leave during any 12-month period. The employer is required to maintain coverage under any group health plan for the duration of the leave as if the employee were continuously employed. Coverage is paid for just as it was when the employee was active, but you should consult legal counsel to determine any reimbursement rights that you may have.

For more information, contact:

U.S. Department of Labor
Pension and Welfare Benefit Administration
Division of Technical Assistance and Inquiries
200 Constitution Ave., NW, Room N-5658
Washington, DC 20210
Or visit: www.dol.gov/whd/fmla/

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA is legislation enacted by the federal government to streamline the health care industry, and provide additional rights and protections to participants in health plans.

Remember, under HIPAA, there are two employer components — the group health plan and the plan sponsor. HIPAA regulations may vary for your company depending on which component wishes to receive PHI, and how much information each component needs.
Section 12 — Retirees

For a retiree of your company to be covered by Anthem, your group must have established a retiree or pension section with Anthem. These special billing sections provide the information for former employees and their dependents to access group health benefits upon retirement. Not every group chooses to provide this level of benefit, and you are under no obligation to do so. Any employer with two or more employees is eligible to establish a retiree section, subject to certain conditions. If someone in your group is retiring and you are reading this section for guidance, more than likely one of the following situations is true for you:

- You do not wish to provide coverage to retirees.
- You do not currently offer retiree coverage and wish to establish that benefit.
- You offer retiree coverage and need to send in the necessary paperwork.
- You are not sure if you have retiree coverage.

Obtaining retiree coverage

Employer obligations

For an employer to obtain retiree coverage, the employer must meet three general requirements:

1. **Retirement plan:** The employer must have a formally documented retiree plan in effect that outlines eligibility guidelines such as:
   - Class of employee eligible for retirement benefits
   - Number of years worked
   - Expected contribution
   - Spouse or dependent eligibility (including survivors of a deceased retiree)

2. **Administration:** The employer must agree to assume all administrative responsibilities in conjunction with the retiree group plan.

3. **Size:** The employer must employ two or more individuals.

Retiree eligibility guidelines

The following items are general eligibility requirements for both Medicare supplement coverage and full group coverage. Employers may have other specific requirements within their own formal retiree agreements which would be incorporated into Anthem’s final retiree eligibility criteria for that particular group. The retiree must transfer to retiree coverage immediately upon retirement. He or she will not be allowed into the group plan at a later date and cannot remain on the active group billing section, unless a late entry is allowed under New Hampshire law.*

- Employees who retire before the establishment of a retiree section may be eligible to enroll if:
  1. They meet the eligibility criteria outlined within the retiree plan,
  2. They enroll when the new retiree section for the group is established, and
  3. Late enrollment is allowed under New Hampshire law.*
Employers should establish the rules for dependent eligibility within their formal retiree document. If dependents are eligible, a retiree may choose to include none or all dependents within the retiree membership. In the case where a spouse has coverage elsewhere and has only one child, the retiree may choose to:

— Enroll as a single parent with one child, or
— Enroll just himself or herself under a single person policy.

A retiree may maintain a membership under the retiree group and also be covered by a spouse’s group membership. However, dual membership, when either partner has a non-group membership, is not permitted.

* In general, New Hampshire law addresses late enrollment only for certain former employees of New Hampshire municipalities.

### Setting up retiree coverage

To set up a retiree section within your Anthem agreement, simply read through the preceding employer requirements and retiree eligibility guidelines, and then call your Anthem Account Manager.

#### What to do when an employee retires and your group has no retiree coverage

Your group has no retiree coverage for one of two reasons:

- Your group has no formal retiree plan document; therefore, you are unable to obtain coverage.
- You have chosen not to establish a retiree section in your agreement with Anthem.

In either case, one of the following applies:

**Retiree is 65 or over**

If the retiree is 65 or older, then Medicare usually becomes the primary payer. The retiree may elect non-group Medicomp coverage. (To elect this, the retiree must have both Parts A and B of Medicare.) If your group is COBRA compliant, the retiree may choose to continue group coverage on COBRA and Medicare is usually prime. If your group is not COBRA compliant, the retiree is not eligible for NH C of C.

Refer to ‘Section 7: Medicare eligible members’ for more specific instructions.

**Retiree is under 65**

If the retiree is under age 65, and not eligible for Medicare, then COBRA or NH C of C is available.

If the retiree is under age 65 and eligible for Medicare,* he or she may elect COBRA, provided that your group is COBRA compliant (20 or more employees) and all other criteria has been met. If the retiree becomes eligible for Medicare after he or she elects COBRA, eligibility for continuation of group coverage may end only if the group’s plan document so designates. If the retiree becomes eligible for Medicare after he or she elects NH C of C, eligibility for continuation of group coverage ends.

Whether a retiree leaves the group directly, leaves a retiree plan or terminates COBRA, he or she may select an available Anthem non-group plan.

Refer to ‘Section 8: Continuation of coverage.’ For more instructions, go to the ‘Removing a subscriber’ section under ‘Section 5: Membership changes.’

* “Eligible for Medicare” means “enrolled in Medicare.”
Section 12 — Retirees

What to do when an employee retires and your group has retiree coverage

If your group has retiree coverage, follow these steps when an employee retires.

**Employee actions**
- Employee completes the Enrollment and Change Forms indicating “Retirement” at the top of the form. Be sure to include any Medicare coverage information that may apply.
- Employee keeps a copy and gives a copy to the benefits administrator.

**Benefits administrator actions**
- Check the Enrollment and Change Forms for accuracy and completeness.
- Keep a copy for your records.
- Complete the Notice of Membership Change Form and keep a copy for your records. Indicate keyword “OTHER” and specify the retiree firm/division number at the top of the form.
- Mail the original or fax a copy of the completed forms to Anthem Blue Cross and Blue Shield. (See ‘Section 1: Important phone numbers and address.’) If you send your forms by fax, do not mail the original paper copy.

**Canceling group retiree coverage**

Retiree Group coverage may be terminated under one of the following two circumstances:

1. **No longer offering coverage**

   If an employer chooses to discontinue retiree coverage, retirees and their covered dependents may be eligible to transfer to non-group Anthem coverage. You may also need to issue certain COBRA notices, if your group is COBRA compliant. Seek legal counsel to determine if COBRA notice is required for retirees.

   **Benefits administrator actions**
   - Provide each enrolled retiree and their dependents written notice that retiree benefits are ending, and COBRA notice as required.
   - Advise the member to contact Customer Service to discuss available non-group options.
   - Provide your Anthem Account Manager with written notice of retiree benefit cancellation.

2. **Cancelling group coverage**

   When the group chooses to cancel its Anthem coverage for another health plan carrier, the retiree section of the agreement must also be cancelled and transferred to the new carrier. Retirees and dependents are not eligible for COBRA continuation or to transfer to non-group Anthem coverage in this circumstance.

   **Benefits administrator actions**
   - Provide your Anthem Account Manager with written notice of cancellation prior to the desired effective date.
   - Specify the new carrier chosen.
   - Indicate all group numbers appearing on your Anthem invoices.
This manual is not a legal policy or contract. It is designed to familiarize you with Anthem administrative procedures. While the information in this manual covers topics that affect your group’s benefit program, the information in this manual is not intended to modify, interpret, replace or govern the terms of the Group Health Care Benefits Contract (GHCBC), or Group Administration Agreements.

This manual does not constitute legal advice or counsel. You should always consult your own legal counsel whenever you have specific legal questions concerning any of the provisions of your group’s benefit program. The procedures followed by Anthem and outlined in this manual may be changed without notice.