Anthem

Health. **Join In.**℠

Group Administration Manual

For All Group Sizes

Missouri and Wisconsin

EMMOWIBRO-195 Rev. 3/11

Member Services Information For Your Convenience

Health Coverage Inquiries

Anthem Blue Cross and Blue Shield

If you have questions about your bill or plan administration, call the phone number printed on your bill.

If you have benefit questions, call the number on the back of the member ID card.

The hours of operation are:
Monday-Friday
Missouri — 8 a.m. - 6 p.m. (CST)
Wisconsin — 7 a.m. - 5 p.m. (CST)

Life and Disability Coverage Inquiries

If you have questions about your bill or plan administration, call the phone number printed on your bill.

PrecisionRx Mail Service Inquiries

PrecisionRx Mail Order Pharmacy Customer Care Associates are available to take your call at:
(866) 302-7155
Monday-Friday
7 a.m. - 9 p.m. (CST)
Saturday 8 a.m. - 7 p.m. (CST)

MyAnthem for Employers

Click on the employer page at anthem.com to find:

- enrollment and employee change form applications
- medical and dental claim forms
- small group termination forms
- Anthem's Time Well Spent kit
- online provider directory
- special offers and much more

Anthem Dental Blue

If you have questions about your Anthem Dental Blue coverage, call:

Missouri/Wisconsin
(866) 589-0582

The hours of operation are: Monday-Thursday,
7 a.m. - 10 p.m. (CST)
Friday 7 a.m. - 7 p.m. (CST)

Anthem Blue View Vision

If you have questions about your Anthem Blue View Vision coverage, call:

866-723-0515

The hours of operation are:

Monday-Saturday, 7 a.m. - 10 p.m. (CST)
Sunday, 10 a.m. - 7 p.m. (CST)

Life and Disability Claims Inquiries

For **Missouri L&D** coverage inquiries, please contact Anthem Life Insurance at:

Anthem Life Insurance Company
Claims Center
P.O. Box 182361
Columbus, OH 43218-2361
Phone: **800-813-5682**
Fax: **614-433-8861**

For Wisconsin, please contact Anthem Life Insurance at:

Life

Atlanta Life Service Center
P.O Box 105448
Atlanta, GA 30348-5426
800-552-2137
404-682-9255 (fax)

Disability

Atlanta Disability Service Center
P.O. Box 105426
Atlanta, GA 30348-5426
800-232-0113
800-850-0017 (fax)

Life Conversion Inquiries

Phone: **800-801-6142**
Fax: **614-433-8316**

Member Services Information for Your Convenience

Health care claim

If the hospital, physician or other facility does not handle claims filing, the employee should send an itemized copy of the bill and a completed form to:

Anthem Member Services

Missouri

Anthem Blue Cross and Blue Shield
P. O. Box 14882
St. Louis, MO 63178-4882

Wisconsin

Anthem Blue Cross and Blue Shield
P. O. Box 34210
Louisville, KY 40232-4210

For more information, refer to "Health Care Claims" in the How to Obtain Health Benefits section.

Precertification and obtaining services

If employees have questions about precertification or how to obtain benefits, they should contact the Customer Service number on the back of their member ID cards or look in their Certificate.

Operational and Utilization Management Appeals Information

Missouri information:

Anthem Blue Cross and Blue Shield
Attn: Grievance and
Appeals Department
P. O. Box 14882
St. Louis, MO 63178-4882

Wisconsin information:

Anthem Blue Cross and Blue Shield
Attn: Grievance and
Appeals Department
P. O. Box 33200
Louisville, KY 40232-3200

Health Conversion

Missouri

800-490-6217

Wisconsin

888-239-9514

Provider directory

If employees have questions about providers, they can find provider information in the Provider Directory or the **anthem.com** online Provider Directory.

To locate a dental provider, your employees can visit the **anthem.com** online directory or call Dental Customer Service.

Forms

Health coverage forms

Contact the appropriate Anthem Member Services units or access information on **anthem.com**.

Dental claim forms

Contact Dental Customer Service or access forms on **anthem.com**.

Life and Disability forms

Contact the appropriate Life or Disability service unit or access information on **anthem.com**.

Insurance Fraud Warning: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Table of Contents

This manual is designed to help employers administer their health benefits from Anthem Blue Cross and Blue Shield (Anthem) and life and disability benefits from Anthem Life Insurance Company (Anthem Life). If you have dental coverage with Anthem, please follow the same administrative guidelines described for health in this manual.

In the event of a discrepancy between this manual and the contract under which the group coverage is provided, the terms of the contract will prevail. The regulations provided in this manual are subject to change from time to time without prior notice.

Employer Responsibilities

As an employer, your responsibilities include:

- giving notice of eligibility to each employee who is or will become eligible for enrollment.
- obtaining and submitting complete enrollment information for eligible employees wishing to enroll. ***Note:*** *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. It should include any changes of classification, benefit amounts and other relevant details when applicable. We may periodically request information that would be contained in the benefits record 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 covered employees in filing claims, if applicable.
- notifying employees of 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.
- notifying employees of any conversion eligibility upon termination of employment, or when coverage is lost due to other events as stated in your Certificate, if applicable.
- notifying Anthem of changes in group size. ***Note:*** *State and federal legislation will alter 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 notification of changes in group size from 2-19, 20-50 and 51+.*
- notifying Anthem if an employee ceases to meet the eligibility requirements set forth in the "Eligibility Requirements" section of this manual.
- notifying Anthem if an employee is not "actively at work" (as defined in the Certificate) on the date coverage would otherwise be effective.
- tracking who is on COBRA, establishing who is no longer eligible for (has used up their time on) COBRA, and notifying Anthem's Billing Department about the status of these individuals, if applicable.
- reporting to Anthem Life Insurance Company the following:
  - employment status
  - ensuring that all eligible employees are enrolled for group term life insurance whenever the employer contributes 100% of the premium payment
  - producing W-2s for any disability benefits (short term or long term) received by employees

Note: *Anthem Life will automatically provide you with an annual disability paid claims report by January 15 of every year.*

Group Participation and Contribution Requirements

(The following requirements outlined are not applicable for Wisconsin. Refer to the Employer Application)

To avoid cancellation of your group's coverage, group participation requirements must be met and consistently maintained.

- Large group's (51+ eligible employees) minimum participation requires the greater of 75 percent of "net eligible" employees or 50 percent of "total eligible" employees.
- Small group's (2-50 eligible employees) minimum participation requires enrollment of at least 75 percent of "net eligible" employees. If the small group enrolls at least 50 percent of the "total eligible" employees, then only enrolling employees and enrolling dependents need to fill out the medical portion of the initial application; for small groups enrolling less than 50 percent of the "total eligible" employees, both waiving and enrolling employees and dependents must fill out the medical portion of the initial application. A minimum of two must be enrolled in health coverage (including husband and wife-only groups).
- "Total eligible" employees are the sum of all eligible employees. "Net eligible" employees are the "total eligible" employees minus those eligible employees who have a valid written waiver due to other group coverage.
- Minimum employer contribution is at least 25 percent of the total cost for health coverage(s) chosen in the event the employee has dependent coverage, and at least 50 percent of the total cost for health coverage(s) in the event the employee has single coverage.
- If the group contributes 100 percent of the premium, then all eligible employees must apply for coverage.
- For **Missouri**, dual choice option plans, a minimum of one person must be enrolled in each plan offering at renewal or the plan will be eliminated.
- Large groups (51+) are required to maintain a minimum of 20 percent of enrolled employees in any plan selected.

Eligibility Requirements

To be eligible, an employee must be:

- Full-time employee working at least 30 hours per week and paid by W-2
- Full-time working owner or partner
- 1099 employee may be eligible if working 30 or more hours per week, work exclusively for the company with which they are applying, and at least 50 percent of the group and at least two covered employees are paid by W-2.

An eligible dependent may be:

- the employee's spouse
- the employee's or spouse's unmarried child(ren)
- the unmarried child(ren) for whom the employee or employee's spouse is the legal guardian.

  The child(ren) must qualify as an eligible dependent as defined in your certificate.
- **(Wisconsin)** grandchild(ren) when the parent is a covered dependent under the age of 18 on the contract.
- for health coverage only, child(ren) who the group has determined are covered under a QMCSO (Qualified Medical Child Support Order)

Note: *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.*

For Life and Disability:

- working the required number of hours per week as stated on the group application and as documented on your group's federal or state payroll records (unless otherwise approved by Anthem Life)
- a member of an eligible class who has satisfied the eligibility waiting period as stated in your Employer Application

Note: *An eligible person may also include a retiree under your group's formal retirement program, but only if the retiree coverage is approved.*

Effective Dates for Your Employees

Timely Enrollment

Timely enrollment occurs when an application is received within the time period stated in the group contract. (See "Late Applications" in the Application Process section of the manual for additional information.)

Employee

After your group's initial enrollment, subsequent new hire enrollment and changes for existing employees will become effective as defined below:

The contract determines the effective days for new hires, which may be either:

a) the **first day** following the completion of your service waiting period, provided the Anthem Enrollment Application is received within the time periods stated in the contract.

b) the **first billing date** following the end of your service waiting period, provided the Anthem Enrollment Application is received within the time periods stated in the contract.

c) the **first of the month** following the end of your service waiting period, provided the Anthem Enrollment application is received within the time periods stated in the contract.

Note: *For Life and Disability, refer to page 23 for additional information.*

Open Enrollment for Late Health Enrollees

For groups 2-50:
The open enrollment period for health enrollees will be 31 days prior to and 31 days after the annual renewal effective date. The late enrollee can apply for coverage at that time.

- If the application is received by Anthem within the 31 days prior to the group's renewal date, coverage will be effective on the renewal date.
- If the application is received by Anthem within 31 days after the renewal date, coverage will be effective one month after the renewal date.
- If the application is received by Anthem more than 31 days after the renewal date, then the applicant is a late enrollee and must wait until the next open enrollment period. The late enrollee may be subject to a pre-existing condition exclusion period as defined in the Schedule of Benefits.

In the event that the renewal date is delayed by Anthem, then open enrollment will be delayed as well. Applications received by Anthem during the initial open enrollment period will be considered timely for purposes of the delayed open enrollment period.

There is no open enrollment for Life and Disability.

For groups 51+:
The open enrollment period for health enrollees will be 31 days prior to and 31 days after the annual renewal effective date.

The late Enrollee can apply for coverage at that time. Coverage will be effective on the renewal date if the application is received by Anthem within 31 days prior to the group's renewal date or up to 31 days after the group's renewal date.

If the application is received by Anthem more than 31 days after the group's renewal, then the applicant is a late enrollee and must wait until the next open enrollment period. The late enrollee may be subject to a pre-existing condition exclusion period as defined in the Schedule of Benefits.

In the event that the renewal date is delayed by Anthem, then open enrollment will be delayed as well. Applications received by Anthem during the initial open enrollment period will be considered timely for purposes of the delayed open enrollment period.

If the group does not have an annual open enrollment period, the late enrollee can apply for coverage at any time. The effective date for the late enrollee will be determined as outlined in the contract.

Application Process

When you enroll for group coverage, we will supply the forms needed to administer the benefits.

Remember to:

- Completely fill out the employer section of the application form
- Have employees complete all appropriate application sections in blue or black ink. This includes: employee signature, date, date of hire, number of hours worked, group number and (For Life and Disability) beneficiary designation.

  Note: *Incomplete applications will cause a delay in enrollment.*
- If applicable, record all changes on the transmittal form with a brief explanation and effective date.
- Have employees complete the "Prior Health Coverage" section of their applications. If there is more than a 63-day lapse between the termination date of the prior coverage and the hire/effective date for the applicant, the prior coverage will not be used to reduce the pre-existing limitation period. The prior carrier's probationary period will not be used to reduce the pre-existing limitation periods, but it will be included to determine whether there has been a break in creditable coverage of 63 days or less.
- Verify the "Other Health Coverage" section of the application has been completed.
- Keep copies of the applications and/or transmittal forms for your records.
- Send all completed original applications to Anthem's membership/billing department for receipt within 31 days following the completion of eligibility.
- Notify Anthem of any employee or enrolled dependents' changes (e.g., address or PCP) by completing the Anthem Change Form Application.

Applying for Coverage

To apply for coverage, the employee must be Actively at Work, as defined in the Certificate, and meet all other eligibility requirements described in the "Eligibility Requirements" section of this manual and the contract.

It is important that the Anthem Enrollment Application form be completed and received by Anthem within 31 days following the completion of the probationary period to ensure the coverage effective date.

Note: *If timely application is not made, the applicant may be considered a late enrollee and may only enroll at the group's next open enrollment period. The individual may be subject to a pre-existing condition exclusion period as defined in the Schedule of Benefits.*

Note: *For L&D, unless timely application is made, coverage may be delayed or denied.*

Managed Care Plans

HMO plans recommend that each applicant and dependent select a primary care physician (PCP) by code from the provider directory. This is important because:

- An employee's medical records and identification of the PCP is dependent upon this code.

Waiving Coverage

To waive health coverage, an employee must complete and sign the Anthem Enrollment Application including the Waiving Coverage section. This will acknowledge that the employee was given the opportunity to enroll.

- If the group contributes 100 percent of the health and/or life or disability insurance premium, all eligible employees must be enrolled for health and/or life or disability insurance coverage. (Does not apply to Wisconsin Small Group.)
- If the group contributes less than 100 percent, employees may waive health and/or life insurance coverage provided the group participation requirements are met.

Changes in Coverage

Every change in coverage (including changing type of coverage) requires a new Change Form, Anthem Enrollment Application or Transmittal Form. Include your group number and the employee's Social Security number on all employee application changes in status.

Changes from employee-only coverage to employee/spouse or dependent coverage and addition of dependent(s) must be received by Anthem within 31 days of the date a dependent qualifies, otherwise the change is only permitted during open enrollment.

Special Enrollment (Qualifying Events)

An individual who was previously eligible for coverage and applies for coverage following the group's initial enrollment period will be allowed to enroll during a Special Enrollment period, if he/she meets the following conditions:

- The employee or dependent declined coverage initially due to other health coverage, and
  - the individual was under COBRA continuation coverage and that coverage has been exhausted, or
  - the individual was under other coverage that terminated as a result of a "loss of eligibility" for coverage or as a result of employer's contributions toward such coverage ceasing, or
- The individual became a dependent of a Certificate holder through marriage, birth, adoption or placement for adoption.

Special Enrollment must be received in writing within 31 days of the date the coverage is terminated, or the date the person becomes a dependent of the Certificateholder. In the case of loss of other coverage, if timely application is made, coverage will be effective as of the date the other coverage was lost. If the enrollment is not received within 31 days of the date the coverage is terminated, then the person(s) will be considered a late enrollee.

For **Wisconsin**, grandchild(ren) may be added to policy if the following occurs:

- The mother or father of the child is already on the subscriber's policy.
- The mother or father of the child is under the age of 18 and not married.

The grandchild will only be eligible for coverage until the mother or father reaches the age of 18.

Note: *Special enrollment must be requested by completing an enrollment application and submitting it to Anthem for receipt within 31 days of the Special Enrollment Event. Special enrollment does not apply to life or disability insurance.*

An employee marries

An employee who is planning to marry should apply to add his/her spouse or to add his/her spouse's dependent children within 31 days of the marriage date by completing an Anthem Enrollment Application form. Coverage will then be effective on the date of marriage.

If the application for dependent coverage is received by Anthem more than 31 days after the marriage date:

- spouse and dependents may enroll only at the group's next open enrollment period.
- a pre-existing condition exclusion period may apply.

Note: *A pre-existing exclusion period may not apply if spouse and dependents qualify for Special Enrollment other than through marriage.*

Newborn Children

Missouri

A newborn is automatically covered the first 31 days following birth. An Anthem Application Form needs to be submitted for a newborn. If the addition of the newborn to the employee's coverage will cause the employee to be in a higher rate classification, then the Application Form must be received by Anthem within the first 31 days following the birth in order to avoid late enrollment and potentially a significant break in coverage for the newborn.

Wisconsin

A newborn is automatically covered for the first 60 days following birth. An Anthem Enrollment Application Form needs to be submitted for a newborn. If the addition of the newborn to the employee's coverage will cause the employee to be in a higher rate classification, then the Enrollment Application Form must be received by Anthem within 60 days of the birth (to avoid late penalties) or up to one year after the birth, if the employee pays all past due premiums plus 5 1/2% interest.

Changes in Coverage (cont.)

Dependents other than newborns

A dependent's coverage becomes effective on the date the dependent satisfies all eligibility requirements, provided timely application is made.

An Anthem Change Form must be received within 31 days of the date the dependent first becomes eligible in order to avoid late enrollment.

Exceptions:

- A dependent's coverage cannot become effective before the employee's coverage is effective.

An Employee adopts a child(ren)

If an employee wishes to add an adopted child(ren), even if the employee is already enrolled with dependent coverage, the employee must submit proper forms and paperwork. This includes an affidavit or copy of legal adoption papers with an Anthem Enrollment Application form. The form must specify the changes, listing current dependents covered and those the employee wishes to be covered.

Adoption of child(ren) younger than age 18

Application for coverage must be received by Anthem within 31 days after the "Placement Date," if the child(ren) is/are younger than age 18. The Placement Date is the date the employee assumed and retained the legal obligation for total or partial support of a child placed with that employee in anticipation of adopting the child.

- Regardless of whether the employee is adopting the child(ren) through an adoption agency or independently, the Placement Date becomes the effective date for the coverage.

If the application for the dependent coverage is received by Anthem more than 31 days after the Placement Date:

- The dependent may enroll only at the group's next open enrollment period, unless the dependent qualifies for Special Enrollment, other than due to adoption.

  Note: *A pre-existing condition exclusion period may apply.*

For **Wisconsin**, the adopted child's effective date will be the date of the adoption or placement for adoption, if you send us the completed change form within 60 days of the event. If additional premium is required for the adopted dependent, the effective date will be the date of the adoption or placement for adoption only if you notify us of the adoption and pay the additional premium within 60 days of the adoption.

Adoption of child(ren) age 18 and older who are considered eligible dependents (must meet dependent eligibility requirements)

Application for coverage must be received within 31 days after the adoption date.

- If the employee has adopted the child(ren) through an adoption agency, the date of adoptive placement as specified in the placement agreement is the earliest effective date of coverage. The actual adoption date may also be used as the effective date of coverage.
- If the employee has adopted the child(ren) through an independent adoption, the effective date of coverage will be either:
  - the date the child is placed in the physical custody of the employee;
  - the date the petition for adoption is filed with the probate court; or
  - the date the adoption is final

If the application for dependent coverage is received more than 31 days after the placement for adoption, the petition for adoption is filed, or the adoption date:

- the dependent may enroll only at the group's next open enrollment period, unless the dependent qualifies for Special Enrollment (other than due to events surrounding adoption).

Note: *A pre-existing condition exclusion period may apply.*

For **Wisconsin**, the adopted child's effective date will be the date of the adoption or placement for adoption, if you send us the completed change form within 60 days of the event. If additional premium is required for the adopted dependent, the effective date will be the date of the adoption or placement for adoption only if you notify us of the adoption and pay the additional premium within 60 days of the adoption. A pre-existing condition exclusion period will not apply.

Note: *A pre-existing condition exclusion period will not apply.*

An employee becomes a legal guardian

A child will become eligible for coverage through permanent legal guardianship when the following requirements are met:

- The legal guardianship papers are presented to Anthem.
- Application for coverage should be received within 31 days of the date legal guardianship is approved by the court.

If the employee wishes to add a dependent child(ren) for whom they have legal guardianship, even if the employee is already enrolled with dependent coverage, the employee must submit an application form specifying the changes.

Note: *Open enrollment is not offered in the life or disability plan. Employees of groups contributing less than 100 percent of the life insurance premium will be subject to medical underwriting. If the group contributes 100 percent of the life insurance premium, all eligible employees must be enrolled for life insurance coverage.*

Late Enrollment

A "late enrollee" is:

- an eligible person or dependent applying for coverage who did not request coverage during the initial group enrollment period or during a Special Enrollment period.
- a newly eligible dependent who failed to qualify during the Special Enrollment period and did not enroll within 31 days of becoming eligible.

Late enrollees may apply for enrollment only at the group's next open enrollment period and may be subject to a pre-existing condition exclusion period as defined in the Schedule of Benefits.

Change in Type of Coverage or Amount of Coverage

A change in an employee's type of health coverage is effective on the date the employee is eligible for the change, provided that the application is received by Anthem in a timely manner.

If the application is not received timely, the person is a late enrollee and the change in coverage may be made at the group's next open enrollment period. A pre-existing condition exclusion period may apply.

An individual will receive the right to request a Certificate of Creditable Coverage upon termination of the health coverage.

Death of an Employee

Please provide us with the employee's date of death. If there is a surviving spouse and/or eligible dependents, please refer to "Continuation of Coverage" section of this manual.

Death of a Spouse/ Dependent(s)

Upon the death of a covered dependent, the employee should complete a change form. The form needs to specify the date of the dependent's death and show appropriate changes to the type of health coverage, if necessary. Any changes of coverage type will be effective after the date of death.

Divorce

Please notify us immediately in the event of an employee's divorce.

- The spouse is no longer eligible for coverage as of the date of the divorce (COBRA coverage may be available.)
- Refer to "Continuation of Coverage" section of this manual for more information.

Dropping the spouse causes a change of coverage type. If the Change Form is received within 60 days of the divorce, we will credit you with the difference in fees paid, minus any unrecovered claims paid, but in the event the change form is received more than 60 days following the divorce, a credit beyond 60 days will not be allowed.

Note: *Documentation (copy of divorce decree or settlement agreement) is required if the application is received more than 60 days after the event.*

Changes in Coverage (cont.)

An Employee Loses Eligibility under Spouse's Coverage

When an employee loses eligibility under a spouse's coverage, he or she must complete an employee application and include the reason for the loss of coverage and the termination date. This application must be received by Anthem within 31 days of the loss of coverage to avoid being considered a late enrollee. Refer to "Special Enrollment (Qualifying Events)" section for guidelines.

An Employee Has Disabled Dependent(s)

This section does not apply to life insurance coverage.

Mentally or physically disabled dependents may continue coverage past the limiting age.

However, in order for benefits to be extended past the limiting age, proof of disability and dependency must be furnished to us by completing the appropriate form within 31 days of the dependent reaching the limiting age. After Anthem determines that a child has met the requirements for continued eligibility, coverage continues indefinitely unless:

- the child marries.
- the child no longer resides with the Certificateholder.
- the child overcomes the disability.
- the child's parent's coverage is terminated.

Annually, we may request proof of continued disability and dependency.

An Employee or Dependent Becomes Eligible for Medicare

When an employee or an employee's spouse or dependent(s) becomes eligible for Medicare by reason of age, disability or end stage renal disease (ESRD), inform us immediately. The primary payer of benefits for these individuals is determined by federal law.

For groups with 2-19 full-time and part-time employees

In general, Medicare is the primary payer and employer group benefits are secondary for employees and employees' spouses age 65 and over.

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, when the group employs 20 or more full- and part-time employees. Federal law requires such employers to offer active full-time employees and their spouses, who are age 65 and older, the same health care benefits offered to employees and their spouses under age 65, and under the same conditions.

The Omnibus Budget Reconciliation Act of 1986 (OBRA) requires an employer of 100 or more full-time or part-time employees to continue the group coverage of its disabled employees as primary until such time as the employees are no longer disabled or are retired. There are certain exceptions to this law.

If the employee cancels his/her employer group coverage and so elects Medicare as the primary payer, Anthem is prohibited from offering coverage to supplement Medicare. Consult your attorneys for additional information on how these laws affect your group.

Dependent Status Change

Once a dependent no longer qualifies as eligible, coverage ends on the date eligibility ends (see the "Eligibility Requirements" and "Continuation of Coverage" sections of this manual).

An Employee Changes Address

The employee must either:

- call Customer Service
- make the change online
- complete a Change Form
- file an application form indicating the new address.

Explanations of Benefits (EOB) and other correspondence are mailed to the address we have on file. It is important that employee addresses are current.

An Employee Drops Coverage

If an employee requests to drop health coverage, notify Anthem immediately. The employee should fill out an application to complete the waiver section. The employee may not be eligible for COBRA, continuation or conversion coverage. Once Anthem receives notification, coverage will terminate at the end of the billing period or on the date requested, as per your Certificate.

An Employee Terminates Employment

Once an employee no longer qualifies as eligible, coverage will terminate at the end of the billing period or on the date requested, as per your certificate. Anthem needs to be notified. (Refer to the “Continuation of Coverage” section of this manual and to your group’s specific guidelines in the contract.)

General Administration

Continuation of Health Coverage

This is only a brief summary of the legal requirements. We recommend that you consult with your tax professionals and attorneys to ensure your company is in compliance with these federal and state laws.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

(Does not apply to life coverage.)

Participation in the employee health and welfare plan, as well as coverage under whatever medical programs are provided by the employer to employees and their dependents, may be continued under a federal law known as COBRA for groups that employ 20 or more employees for at least 50 percent of the previous calendar year. Administration, for the purpose of compliance with COBRA, is the obligation of the employer under this federal law. Anthem is not responsible for COBRA administration unless you have specifically contracted with Anthem, through a separate COBRA administration contract, for COBRA services. The employer is responsible for providing satisfactory notice to employees regarding COBRA benefits, disclosure, and other administrative obligations imposed under ERISA.

COBRA continuation is available only if the application (timely) and premium payment requirement of the law are met.

Individuals covered by an employer-based group plan are entitled to elect to remain in such plan after coverage otherwise would expire due to a qualified event. Please see details below.

The period of continuation of coverage is 18 months from the date of the qualifying event for employees (and their dependents) in case of loss of coverage through:

- covered employee's reduction in work hours (including layoff and strikes).
- covered employee's voluntary or involuntary termination of employment (other than gross misconduct) including retirement.

The period of continuation of coverage is 29 months from the date of the qualifying event for:

- an employee (and dependents) or a dependent who is determined by the Social Security Administration to have been disabled at the time of the qualifying event or within 60 days thereafter when coverage terminated due to one of the above and continues to be disabled after the 18-month continuation period expires.

The period of continuation of coverage is 36 months from the date of the qualifying event for:

- surviving spouses and children of deceased covered employees.
- covered dependents of employees who become entitled to Medicare benefits.
- legally separated or divorced spouses, and dependent children.
- children of current covered employees who no longer qualify as dependent children.

Children born to or adopted by a COBRA-qualified beneficiary may be added to the COBRA coverage with an application received by Anthem within 31 days of birth or placement for adoption.

Application for COBRA coverage

A COBRA-eligible person should be provided with a timely election notice and may elect COBRA within the 60-day period from the date coverage would otherwise end. To apply for COBRA coverage, the person must complete an application form selecting COBRA coverage.

Termination of COBRA coverage

COBRA continuation coverage may terminate prior to expiration of the continuation period upon:

- termination of all health plans provided to employees.
- COBRA-covered individual's failure to pay premium.
- COBRA-covered individual becomes covered (after electing COBRA) by another health plan with no applicable pre-existing condition limitation.
- coverage under Medicare after electing COBRA.
- other reasons for termination provided in the Certificate.

Other coverage may be available. (Refer to "Continuation of Coverage" section of this manual for more information.)

State continuation of coverage

Under **Missouri** law, for groups with less than 20 employees, and church and government groups, an employee may have a right to continue health coverage upon termination of employment or membership if the employee has been continuously insured under a group policy during the entire three months preceding termination of employment and meets certain other Missouri law requirements. See Section 376.428, RSMo for more information.

For the covered spouse who is 55 years of age or older at the expiration of COBRA coverage and any children of an employee, additional Continuation Coverage may be available under Missouri law after they use up their federal COBRA Coverage. (For requirements of this provision, check the State of Missouri Web site, http://insurance.mo.gov/ consumer/ faq/lhfaqs.htm, and go to the Revised Missouri Statute, sections 376.892 and 376.893.

Under **Wisconsin** law, an 18-month extension is available to the employee if he/she loses medical coverage for a reason other than misconduct on the job, and to the employee's dependents if the employee dies or becomes divorced.

The person electing the extended coverage must have been covered under this plan for at least three months. He or she must be a Wisconsin resident, pay timely premiums, and not be eligible for similar coverage under another group policy. The election and initial premium payment must be made within 30 days of leaving the group.

Coverage under a Qualified Medical Child Support Order

Under federal law, employer-sponsored group health plans must provide benefits in accordance with the requirements of a Qualified Medical Child Support Order (QMCSO). A Medical Child Support Order (MCSO) is any judgment, decree or order issued by a court with jurisdiction made pursuant to a state domestic relations law or which enforces a law relating to medical child support under Medicaid. Such a court order creates or recognizes the right of an employee's child to receive benefits under the plan.

In the event you receive an MCSO, you should provide notice to the child, or a representative, and the child's parent who is the Certificateholder. The notice should include your procedures for determining whether a MCSO is a QMCSO.

You should make a determination within 10 days of receipt of whether an MCSO is a QMCSO. Send the child (or a representative of the child), and the child's parent (who is the Certificateholder) notice of the determination. Also notify Anthem of this determination. Include a copy of the QMCSO, a copy of the court order and an Anthem Enrollment Application. At that time, the child can be added as a dependent.

You should review the court's order in accordance with the requirements of Section 609 of ERISA and any regulations issued concerning QMCSOs. If the court's order appears to be in compliance with those requirements, coverage of the child will commence on the date ordered by the court. If the court's order does not appear to be in compliance, it should be returned to the court with a list of any apparent deficiencies noted by the group. When you receive a new or supplemental order remedying deficiencies, coverage of the child will commence retroactively to the date of the court's order.

This is only a brief summary of the law's requirement. We recommend you consult with your attorneys to implement this law in your company.

Coverage during Strikes for Health Benefits

In the event of a strike, coverage terminates as of the last date through which premium has been paid. COBRA should be offered to striking covered employees.

Depending upon the length of the strike, the following will apply if COBRA is NOT elected:

If the strike lasts ...

- 63 days or less— coverage may be reinstated and effective the day the employee returns to work after the strike ended. No additional pre-existing condition exclusion period will apply.
- more than 63 days — the employee will be considered the same as a new employee. The employee may be subject to a pre-existing condition exclusion period.

If a striking employee previously covered by Anthem prior to the strike elects COBRA and pays COBRA premiums, the above does not apply. Instead, when the strike ends, the employee will go from COBRA status to being an active employee with no break in coverage upon returning to work.

If a striking eligible employee returns to work and did not have coverage prior to the strike, the employee will be treated as a late enrollee and must apply for coverage during the group's next open enrollment period.

If a striking employee returns to work and had not yet completed any applicable waiting period, the employee must complete the waiting period to become eligible for coverage. At that time the employee may enroll as a new employee. The period of time the employee was on strike does not count toward completion of the waiting period.

New Anthem Enrollment Applications for all striking employees returning to work, whether they elected COBRA or not, must be received by Anthem within 10 days of the date the strike ends and noted as such.

Coverage for Health Benefits during Disability

If a covered employee is no longer working full-time due to a sickness or injury, you may continue the employee's coverage under the group plan. This can happen as long as you consider the individual an employee for federal and state tax purposes, the employee continues to meet eligibility requirements under the contract, and by paying the required premium. Once employment is terminated, the "Continuation of Coverage" section applies.

Note: *Exceptions to this are described in "Continuation of Coverage" in the General Administration section of this manual.*

Note: *The group must submit a termination request. (Refer to the "An Employee Terminates Employment" section in this manual.)*

Continuation of coverage for layoff, leave of absence or disability, terminates at the end of the period specified in the "Continuation of Coverage" section. The employee must return to active, full-time employment and have another qualifying event to be able to reapply for continuation of coverage.

Coverage for Rehires for Health Benefits

For groups 2-50:

- If an employee has lost coverage due to a layoff, but is then rehired within 63 days and placed back on the group plan, that employee's earliest effective date of coverage will be the date of rehire. The probationary or service waiting period will be waived. (Any unused pre-existing condition exclusion period from the coverage prior to layoff will be applied.)
- If more than 63 days has elapsed between the date of termination of the group coverage and the rehire date, the group's probationary or service waiting period will apply. The full pre-existing condition exclusion period may apply.

Note: *If the employee was offered and elected COBRA or Continuation of Coverage, so there was no break in coverage, this paragraph does not apply.*

The Anthem Enrollment Application must be submitted and should identify the applicant as a person returning from layoff, the date of layoff, and the date of rehire. **The Anthem Enrollment Application must be received by Anthem within 10 days of the date of rehire.**

For groups 51+:

- Based upon the written request from an employer with more than 50 full time employees, special provisions may be made by Anthem for employees who are laid-off from work and for their dependents. The provision must apply uniformly to all laid-off employees. Upon return to work, the employee must meet current eligibility requirements.
- The Anthem Enrollment Application must identify the applicant as a person returning from layoff, the date of layoff, and the date of rehire. **The application must be received by Anthem within 31 days of the date of rehire.**
- In the absence of special provisions by Anthem, if the person is rehired within 63 days after layoff, the probationary or service waiting period may be waived. Any unused pre-existing condition exclusion period from the coverage prior to layoff will be applied.

Note: *If the employee was offered and elected COBRA or Continuation of Coverage, so there was no break in coverage, this paragraph does not apply.*

Conversion Option

A conversion health coverage policy is available for certain persons under group policies in Missouri and Wisconsin.

If a person has been continuously covered under the group contract for at least 90 days and the person's group coverage ends, the person may have the option to purchase a conversion policy. Conversion coverage will be different from the coverage provided under the Group Certificate.

Note: *In Missouri and Wisconsin, it is the employer's responsibility to notify eligible employees of their conversion options.*

An option to purchase a conversion policy is available to:

- an employee, when group coverage ends due to termination of employment in the group. The conversion policy may cover the employee and eligible dependents who are covered under the group's policy.
- a spouse, when group coverage ends due to a legal separation or divorce.
- a surviving spouse, when group coverage ends due to employee's death. The conversion policy may cover the spouse and dependent children who are covered under the group's policy.
- a child who ceases to be a dependent due to reaching the maximum age limit. (not applicable in Wisconsin)
- an employee or an eligible dependent (see the "Glossary of Terms" section for more information) who has exhausted COBRA benefits and is ineligible for state-specific continuation of coverage.

Individuals are not eligible for a conversion policy if:

- eligible for other group coverage.
- eligible for state, federal or other coverage that duplicates Medicare.
- individual elected to continue group coverage under state or federal law, and the continuation period for which the employee is eligible has not ended.
- covered by this group plan as a retiree.
- the individual establishes residence outside the state (Wisconsin only).

The individual must apply in writing to Anthem for conversion. Please refer to the group Certificate to determine when Anthem must receive the application for conversion.

The individual must pay for conversion coverage from the date he or she stops being a covered person under the current group Certificate. Coverage under the conversion policy will start on the date the coverage under the current Group Plan Certificate ends.

In Missouri, the application and initial premium payment must be made within 31 days of the termination of coverage.

In Wisconsin, the application and initial premium payment must be made within 30 days of the delivery of the employer's notice of conversion (employer must deliver notice within 5 days after being notified to terminate coverage).

How to Obtain Health Benefits

Services Requiring Precertification

Precertification means that Anthem must authorize certain covered services before expenses are incurred. Both medical necessity and appropriate length of stay will be determined.

- Medical necessity includes a review of both the service and the setting.
- The care will be covered according to the benefits for the number of days approved unless our concurrent review determines the number of days should be revised.
- Certain services may require the use of a provider designated by Anthem's Health Care Management staff.
- Precertification does not guarantee payment — coverage is subject to the terms of the benefit plan and payment of premium for the period during which services are rendered.

Precertification is not required for emergency admissions. However, the employee must notify us of the admission. Refer to the group Certificate for important details about precertification.

Precertification Responsibility

If an employee has HMO, POS or PPO coverage, his or her network doctor will handle the precertification with Anthem when services are within Anthem's service area. If the employee is outside the service area, precertification is his or her responsibility.

If an employee seeks services out of the network or has coverage other than HMO, POS or PPO, he/she is responsible for obtaining precertification. Please review your group Certificate for specific precertification requirements. Your employee should call the precertification number listed on the back of his/her Anthem ID card.

Transplant Precertification

Depending on coverage, transplant services may be covered at a reduced benefit, if:

- the employee fails to obtain precertification.
- the employee uses a provider other than the one designated by Anthem.

Additional penalties may apply.

Health Care Claims

For inpatient and outpatient care, an employee or dependent should show his or her current identification card. The health care provider will usually handle the paperwork.

If the hospital, physician or other facility does not handle claims filing, the employee should send an itemized copy of the bill and a completed claim form to:

Anthem Blue Cross and Blue Shield Claims Department

For Missouri

Anthem Blue Cross and Blue Shield
PO Box 14882
St Louis, MO 63178-4882

For Wisconsin

Anthem Blue Cross and Blue Shield
P. O. Box 34210
Louisville, KY 40232-4210

The bill must be itemized and include the employee's identification number (including three-letter prefix), name and address, patient's name, date of birth, diagnosis and procedure codes.

Next Rx Network, Next Rx Direct and/or Dental Care Claims

If your group is enrolled in Next Rx Network, Next Rx Direct and/or Dental, claim forms are available from most providers, Anthem's Member Services unit or at **anthem.com**.

For more information, refer to the "Member Services Information for Your Convenience" section of this manual.

Fully Insured Billing — Keeping the Payment Process Simple

Spend Less Time on Administration and More Time on Your Business

The "pay-as-billed" policy is easy to understand and follow.

- Pay the total amount due on the bill.
- Do not add or delete members by writing on your bill.
- Submit membership changes as they occur. Do not submit them with the premium payment. This allows you to obtain:
  - timely addition of new members
  - timely receipt of ID cards
  - simplified access to care
- When members are added or deleted after the billing date, we will adjust your premiums on the next bill. The last page of your bill reflects these retroactive adjustments. If membership changes are not received before the bill is processed, then it will be reflected in the following bill.
- Claims processing is timely — even for members not yet listed on the bill. Their claims will be processed as long as:
  - you have submitted the membership changes
  - we have processed those changes
  - your group is paid up to a current date

Premiums should be paid in full by the due date to avoid cancellation. Coverage is automatically terminated if payment is not received by the specified due date.

Employers are responsible for notifying all Certificateholders when health coverage is terminated due to the employer's failure to pay the required premium. We recommend that you consult with your legal counsel regarding the notifications.

Billing Statement

You will receive a bill for the group fees approximately 10 days before each due date. The bill will list all employees who were enrolled in the group at the time the bill was prepared. **Do not add names to the billing statement or add premium for employees not listed on the billing statement. We will bill for any back charges on subsequent billing statements.**

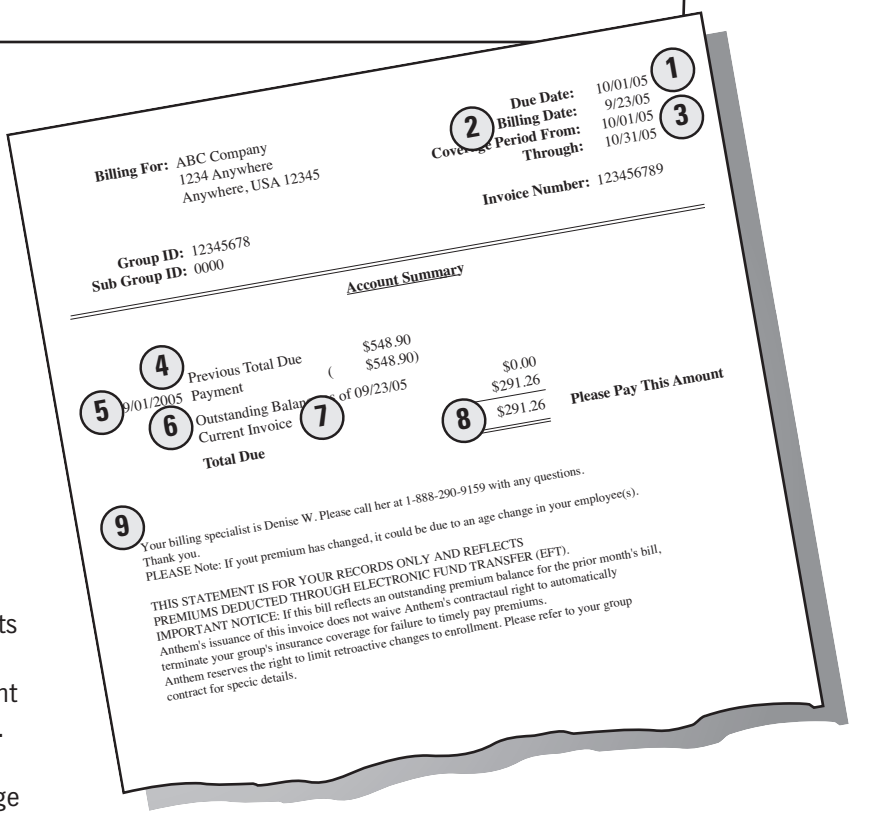
After receiving the bill:

- Check to make sure all persons listed on the bill are active employees working the required number of hours or more per week and still eligible to remain in the group.
- If there are employees listed who need to be removed, follow the procedures as outlined in the "Changes in Coverage" section of this manual.
- Employers have the responsibility for collecting and remitting payments to Anthem as they come due. Anthem does not assume any liability to members enrolled hereunder by reason of any delay or failure of the employer to remit applicable payments.
- Mail the **full** payment and the payment stub in the return envelope so that it is received by Anthem by the due date.
- Keep a copy for your records.
- If the bill is not paid in full and received by Anthem by the due date, claims payment will be suspended for the group (except for claims for Wisconsin group members and death claims as described in the "Life Insurance" section of this manual). Coverage will be cancelled automatically as provided in the Group Contract.

Account Summary

This section of your bill is the primary summary page that outlines what the group is expected to pay. It includes the following:

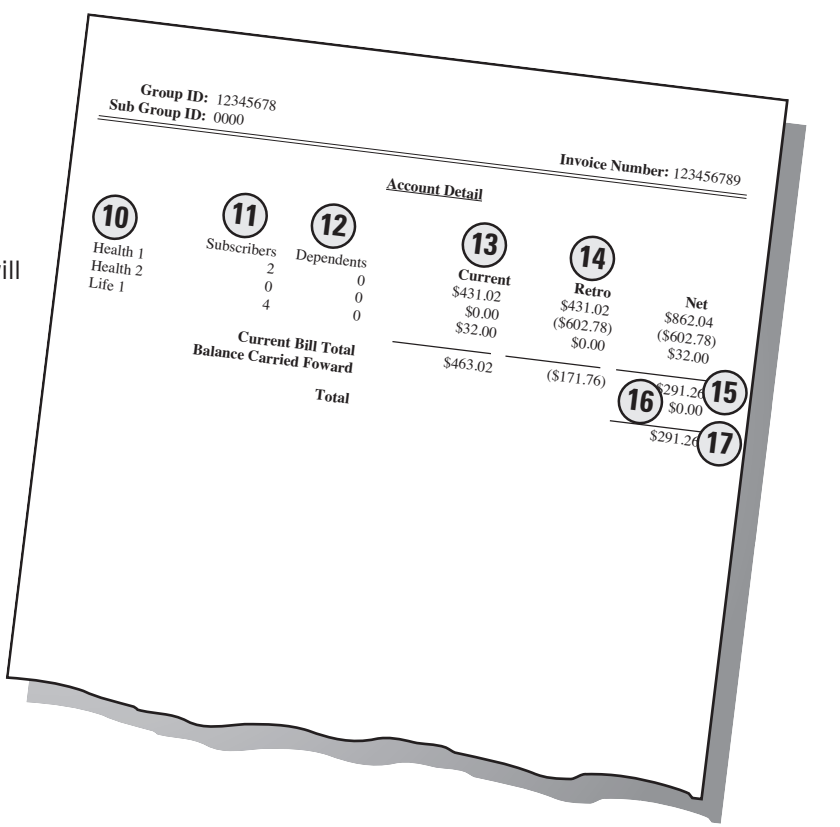
1. Date premiums are due to Anthem.
2. Date the bill was generated.
3. Premiums on the bill are for this period of time.
4. Amount(s) due from the prior billing period(s).
5. Date and payment amount received.
6. Balance due from prior billing period(s).
7. Amount due for the current billing period. (Reference from Account Detail — line 17.)
8. Total amount due from the group (line 6 plus line 7). PLEASE PAY THIS AMOUNT. All debits/credits will be adjusted on the next bill as retroactive adjustments. Before the due date, mail the payment and payment stub in the return envelope provided. If bills are not paid in full by the due date, claims payments will be suspended for the group. Coverage will be cancelled automatically as provided in the group contract.
9. Messages related to your bill, such as who to call with billing questions.

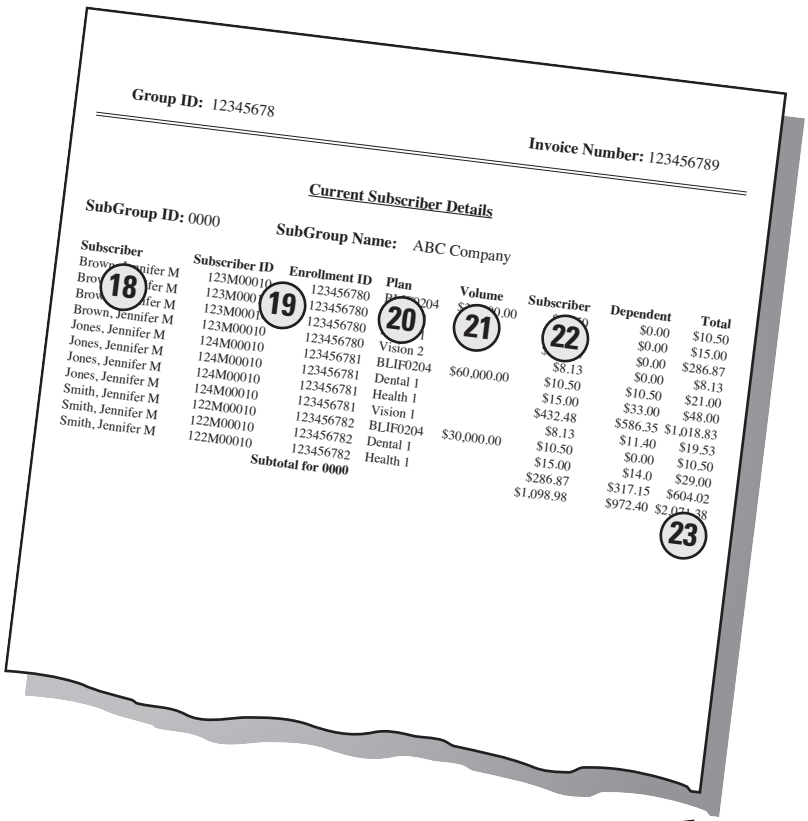


Account Detail

This section of the bill is a summary of premiums by product, subscriber and dependent. It includes the following:

10. Health Plan(s) selected by the group. Multiple plans will appear as separate line items.
11. Number of subscribers being billed as of this billing date.
12. Number of dependents being billed as of this billing date.
13. Amount of current premium due for this billing period from Current Subscriber Details (line 23).
14. Amount of retroactive premiums or credits due as of this billing date from Retroactive Adjustments (line 30).
15. Total current premium due for this billing period (line 13 plus line 14).
16. Balance due from prior billing period(s).
17. Total amount due (line 15 plus line 16).





Current Subscriber Details

This section of the bill contains detailed billing information on CURRENT premiums for each subscriber. It includes the following:

18. Name of the subscriber(s) billed as part of the group.

19. Anthem subscriber identification and Enrollment ID numbers.

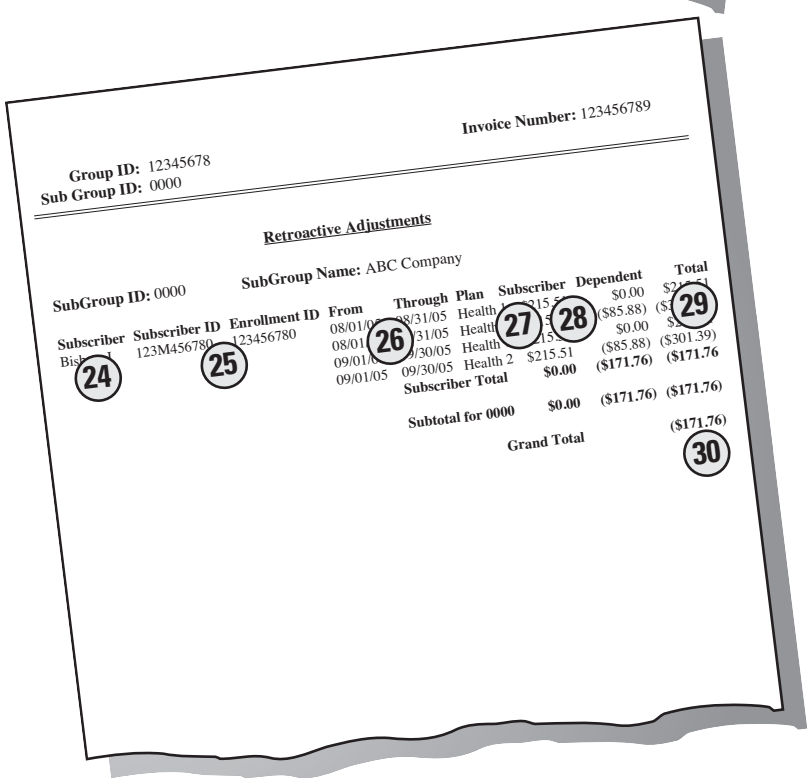
20. Anthem's health plan selected by each subscriber.

21. Indicates how much Life Coverage the subscriber has/value of their policy.

22. Amount of premium due for each subscriber.

The "*individual subscriber*" and " " premium amounts will also be shown on the bill.

23. Total amount of premium due, for each subscriber, billed in the current billing period (by subgroup if there is more than one subgroup).



Retroactive Adjustments

This section of the bill contains detailed billing information on RETROACTIVE premiums for each subscriber. Retroactive adjustments include all subscriber changes that occurred, but were not processed, during a prior billing period. These transactions include new subscribers, terminated subscribers and subscribers who have changed coverage. It includes the following:

24. Name of any subscriber who had changes that occurred, but were not processed, during a prior billing period.

25. Anthem Subscriber Identification and Enrollment ID numbers.

26. Period in which the prior adjustment occurred.

27. Adjust premium amount for each subscriber by billing period. The "individual subscriber" and "dependents" premium amounts will also be shown on the bill.

28. Adjusted premium amount for each subscriber by billing period.

29. Sum of premium due if a subscriber has more than one adjustment listed.

30. Total adjusted premium for changes that occurred in prior billing period(s) but were not processed until the current billing period.

Fully Insured Billing — Keeping the Payment Process Simple (cont.)

Self-administered Instructions for Life Insurance

Groups that maintain life insurance benefit information for their employees use the Premium Report to calculate and report group life and disability coverage to Anthem Life. Prepare this report each month, and send it along with your premium payment. Keep a copy for your records.

Online Services

Anthem believes in having a strong focus on technology, which is why we have many online services that you and your employees can use to save time, save money and eliminate hassles.

For Employers

MyAnthem™ for employers

With this tool, you will be able to register for timesaving and easy-to-use self-service features through the ***MyAnthem*** link on **anthem.com**. You will have the ability to add, change or terminate employees and dependents, and you will also be able to view employee claims and benefits information. This includes being able to view or change an employee's address, view an employee's PCP and details on an employee's claim status, view your company's benefits through your online certificate, request an ID card for an employee, and more.

For Your Anthem Members

Web enrollment

If you are a new large group (51+ employees) on Facets, you can enroll your employees online with Member Web Enrollment. By using this secure Internet-based tool, your employees can complete their enrollment applications online, allowing you to:

- reduce paperwork
- streamline enrollment
- eliminate delays
- simplify management
- quickly review and submit applications
- make benefits management easier

MyAnthem for members

MyAnthem is an easy-to-use, secure site that simplifies the way your employees manage their benefits. It also helps them understand more about their health plan and how to use it. They'll have the ability to find a doctor or hospital, check a claim status, order a new ID card, make updates to their personal information, and find customized information based on specific criteria that applies to them. Your employees can also view benefit, prescription, health and wellness information, and more.

SpecialOffers@Anthem℠

SpecialOffers@Anthem is accessed through ***MyAnthem***. It offers your employees discounts on a variety of health and wellness-related items and services.

MyHealth@Anthem®, powered by WebMD®"

MyHealth@Anthem is an easy-to-use, extensive library of more than 20,000 articles and much more. Accessed through ***MyAnthem***, ***MyHealth@Anthem*** and it also offers your employees "cool tools" such as health calculators and assessments. Your employees can sign up to receive health-related e-mail newsletters from this Web site.

Healthcare Advisor®

The ***Healthcare Advisor***, is a tool designed to empower employees to make the best health care choices. It is accessed through ***MyAnthem*** and helps your employees discover more about treatment options, what questions to ask when talking with a doctor, what to expect when facing an illness, compare hospitals, and more.

Online Services (cont.)

Treatment Cost Advisor™

The ***Treatment Cost Advisor*** helps your employees estimate their annual health care expenses and out-of-pocket costs based on the different plan options. With this tool, they can:

- Find cost information for many common medical conditions and health care services
- Get reliable cost estimates adjusted to your age, gender and location
- Compare costs between network and out-of-network providers and facilities

PharmaAdvisor™

PharmaAdvisor is available to your employees who are Anthem Prescription customers. These employees may access ***PharmaAdvisor*** through ***MyAnthem*** to perform the following functions:

- view detailed information about drugs
- access side-by-side comparisons of the drug side effects, role in treatment, and actions of different drug classes used to treat their conditions
- review a customized checklist of questions to ask a physician
- use a drug interaction checker to retrieve information on different drug interactions
- learn what to expect after starting a new medication

Note: *Anthem will continue to update online services, so watch for future enhancements to our tools and self-service features.*

Coverage Advisor™

CoverageAdvisor can help your employees understand which health care services they and their dependents are likely to need — whether they are very healthy or have multiple health conditions. Then, it will estimate the annual cost of those services. ***CoverageAdvisor*** gives your employees the confidence to make informed choices when it's time to pick a benefit plan because it walks them through:

- developing a profile
- estimating their medical needs
- estimating their health care costs
- reviewing any tax implications

Termination

Group Plan

The group plan will continue in force unless terminated by you or us. Details regarding rights of termination, including notice requirements, are contained in your Contract.

Please note: *In the event of a discrepancy between this manual and the Contract under which the group insurance is provided,the terms of the Contract will prevail. The regulations provided in this manual are subject to change from time to time without prior notice.*

Life and Disability Insurance

This section is applicable only if your group's benefit plan includes life and/or disability insurance. This section is in addition to any requirements that may be outlined elsewhere throughout this manual.

Group Participation Requirements

If your group contributes 100 percent of the premium for any employee coverage, then all eligible employees must apply for that coverage.

- If your group contributes 100 percent of the premium for dependent coverage, then all eligible employees with dependents must apply for dependent coverage.
- If your group contributes less than 100 percent of the premium for employee coverage, then at least 75 percent of all eligible employees must be enrolled at all times.
- If your group contributes less than 100 percent of the premium for dependent coverage, then at least 75 percent of all eligible employees with dependents must be enrolled with dependent coverage at all times.
- Optional Life participation may vary.

Premiums

Premiums for life and/or disability insurance are billed on a monthly basis, and may be separate from the health insurance billing. The premiums must be paid on or before the due date. A pre-addressed return envelope is included with the billing statement.

NOTE: *Do not adjust your bill to reflect changes in membership. Please report membership changes to the bill on an Anthem Enrollment Application. The changes will be reflected with any necessary adjustments on the next month's bill.*

Enrolling New Employees

An Anthem Enrollment Application must be submitted to enroll a new employee in life and/or disability insurance.

- If the application form is not submitted within the time periods stated in the group certificate, the employee will be subject to medical underwriting, which means that satisfactory evidence of insurability must be submitted. Late entrants on groups contributing 100% of the premium will be subject to retroactive premium charges
- If the employee is not actively at work (as defined in the Certificate) on the day preceding the effective date, coverage starts on the date the employee returns to active work.

Evidence of insurability will be required:

- when the employee or dependent applies for coverage more than 31 days after he/she becomes eligible;
- for group term life insurance amounts in excess of the guarantee issue limit; and
- for any other reason in accordance with our current standard underwriting procedures and guidelines.

Note: *Evidence of insurability must be sent to Anthem Life immediately.*

Change in Coverage or Amount of Insurance

A change in an employee's insurance coverage is effective on the date the employee is eligible for the change, provided timely application is made and any evidence of insurability which may be required is accepted. In most cases, if timely application is not made, the effective date will be the first billing date following receipt of the employee's application, provided evidence of insurability is submitted. Coverage is subject to underwriting approval when evidence of insurability is required.

A change in an employee's amount of insurance, due to a salary change or a classification change (i.e., occupation change), is effective on your group's next billing date following the date of the change (subject to approval of any evidence of insurability which may be required).

Note: *Any increase in coverage is subject to the same actively-at-work requirement for an employee and non-confinement requirement for a dependent.*

Divorce

If an employee has covered dependents, please notify us immediately in the event of an employee's divorce. Upon divorce, the spouse is no longer eligible for coverage. If the employee no longer has dependents to be covered, the employee should cancel dependent coverage by submitting an application form requesting the change. The change will be reflected on the next billing date after we receive the request for cancellation.

Ending Coverage

It is the employer's responsibility to notify Anthem Life of a requested cancellation in coverage due to termination of employment or other reasons. This includes death of the employee. Notification must be given by completing an Anthem Enrollment Application or Change Form. Do not submit this form with your premium payment. Life and/or disability coverage cannot be dropped if the group contributes 100 percent of the premium, or unless approved by Anthem Life Insurance Company.

Rehire Provisions

If an employee has lost coverage due to layoff or termination and is then rehired within 365 days and placed back on the group plan, that employee's earliest effective date of coverage will be the date of rehire. The probationary or service waiting period will be waived. The Anthem Enrollment Application must be submitted and should identify the applicant as a person returning from layoff, the date of layoff and the date of rehire.

Coverage during Layoff and/or Leave of Absence

In the event of a layoff or an approved leave of absence, you may typically continue an employee's group life insurance for up to three consecutive months by paying the required premium (unless otherwise stated in the group certificate). Continuation of coverage time periods, insurance benefits and requirements may vary. You should refer to your group certificate and/or policy for specific guidelines. If the employee has not returned to active, full-time work at the end of the continuation period, the employee's insurance coverage(s) should be terminated.

Group life insurance includes group term life insurance, accidental death and dismemberment (AD&D), optional group term life insurance, optional accidental death and dismemberment and group term life insurance for dependents.

Coverage During Disability

If a covered employee is no longer actively-at-work due to a sickness or injury, you may typically continue the employee's coverage under the group plan for up to six consecutive months by paying the required premium. At the end of the period of continued coverage, the employee's insurance coverage(s) should be terminated (except as described below).

- If an employee is totally disabled and the group plan includes extension of benefits or waiver of premium for group term life insurance, that life insurance may be continued as described in the group's certificate. Generally, waiver of premium benefits are available only if the total disability began before age 60. The employee must file a claim in order to qualify for these benefits. Refer to the "How to Obtain Benefits" section of this manual.

Life and Disability Insurance (cont.)

Newborn Children

If dependent life insurance coverage is in effect on the date of birth, coverage will begin for a newborn child when the child reaches 15 days of age (unless stated otherwise in the group certificate).

If dependent life insurance coverage is not in effect on the date of birth, dependent coverage will begin for a newborn as described below.

- If application is made within 31 days after the date of birth, coverage will begin at 15 days of age, unless stated otherwise in the group certificate.
- If application is not made within 31 days after birth, the effective date is the first billing date following receipt of the employee's application, provided evidence of insurability is submitted. Coverage is subject to underwriting approval when evidence of insurability is required.

EXCEPTION: *If a newborn is an inpatient on the day preceding the date coverage would otherwise become effective, the newborn's effective date will be delayed until there is a lapse of three consecutive days during which the newborn has not been an inpatient.*

Dependents Other Than Newborns

A dependent's coverage becomes effective on the date the dependent satisfies all eligibility requirements, provided timely application is made.

If application is not made within the time period stated in the certificate, in most cases coverage will become effective on the first billing date following receipt of the employee's application, provided evidence of insurability is submitted.

Coverage is subject to underwriting approval when evidence of insurability is required.

EXCEPTIONS:

- In no event will a dependent's coverage become effective before the employee's coverage is effective.
- In no event will a dependent child's life insurance become effective before the child is 15 days old (unless stated otherwise in the group certificate).
- If a dependent is an inpatient on the day preceding the date coverage would become effective, that dependent's effective date will be postponed until there is a lapse of three consecutive days during which the dependent has not been an inpatient.

Required Information Checklist

Forms can be viewed and printed (go to **anthem.com**, click Anthem Life Insurance Company, then select Online Forms). You may also request forms to be faxed or mailed to you by calling Anthem Life at **866-551-0315** or send a written request to:

Anthem Life Insurance Company
Attn: Group Administration
P.O. Box 182361
Columbus, OH 43218-2361

Change in beneficiary designation

Complete the Life section of the Anthem Enrollment Application form for existing employees and/or beneficiary form.

NOTE: *Please maintain a copy of all beneficiary designations and beneficiary changes for your records.*

Request for life insurance conversion

An employee whose coverage terminates may have the right to convert the group term life insurance to an individual whole life insurance policy without evidence of insurability. A brief description of the conversion right follows. Refer to the Certificate or contact Anthem Life's Conversion Inquiry department for more information.

Note: *The employer should notify eligible persons of their conversion right. Anthem Life will* ***NOT*** *send conversion notices to terminated employees, neither will Anthem Life extend the time period allowed for a person to apply for a conversion policy even if you fail to provide timely notice of the conversion option to the person.*

The right to purchase a conversion policy is available when the employee's life coverage ends for a reason other than the group's coverage ending or changing. The individual 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 individual may choose to be insured for the same or lesser amount as insured under the group plan. Premium will be calculated according to the individual's age and class of risk. The conversion policy will become effective on the date that group term life insurance ends, provided the person applies and pays the conversion premium within 30 days. Conversion is also available when an employee loses coverage because the group plan terminates or changes. In this case, additional limitations apply.

The Employer and Employee must complete a Notice of Conversion form and send it to Anthem Life requesting conversion. Anthem Life will then mail the conversion application and rate information to the employee who must then return the completed application and pay the initial premium on the policy within 30 days after the group term life ends.

Life Insurance Claims

To submit a life insurance claim:

- The beneficiary/claimant must complete, sign and date the claimant's statement portion of the claim form.
- If no beneficiary designation is on file, the beneficiary will be as stated in the insurance certificate. If the claim is on a dependent, the employee is the beneficiary.
- The beneficiary/claimant must obtain a certified copy of the death certificate.
- The beneficiary/claimant must provide the completed claimant's statement and the certified copy of the death certificate to the employer.
- The employer must complete the employer's statement portion of the claim form.

NOTE: *For employee life claims, please also attach all enrollment forms and beneficiary change forms, if available.*

Payment of life insurance proceeds

For proceeds of less than $10,000, we'll pay benefits to the last designated beneficiary. We'll mail the check to the beneficiary/claimant unless we're otherwise instructed on the claim form.

For proceeds of $10,000 or more, instead of paying benefits by sending a single check, we deliver life insurance proceeds to beneficiaries in the form of an interest bearing account. Once a claim for $10,000 or more is approved, we establish a special account for the beneficiary. We then mail a personalized Anthem Access Advantage checkbook to the beneficiary the next business day. The beneficiary has immediate access to all or a portion of the proceeds simply by writing a check. This allows beneficiaries to use the account to pay for immediate expenses, while relieving them of the pressure of making important investment decisions during a time of stress and grief.

The account begins earning a competitive rate of interest starting on the day it's opened.

Accidental death benefit claims

To submit an accidental death benefit claim, follow the steps outlined in the Life Insurance Claims subsection. Please also attach any available newspaper articles and police or coroner reports that provide details of the accident.

We'll deduct any dismemberment proceeds previously paid for the same accident under the insured's accidental death and dismemberment (AD&D) coverage from the AD&D proceeds due for accidental death.

Accidental dismemberment benefit claims

To submit an accidental dismemberment benefit claim, check the dismemberment box at the top of the Disability Claim Form and follow the steps in the Short-term Disability Claims Subsection. You may also use the Dismemberment Claim Form to submit this type of claim.

Anthem Life will issue the appropriate dismemberment benefit and mail the proceeds to the employer for delivery to the employee unless the employer has requested we mail the check directly to the employee.

Waiver of life premium claims

If an employee's coverage includes waiver of life premium during total disability coverage, a claim must be filed to obtain this benefit.

To submit a waiver of premium benefit claim, check the waiver of life premium box at the top of the Disability Claim Form and follow the steps listed in the Short-term Disability Benefit Claims subsection. You may also use the Waiver of Premium claim form to file for this type of claim.

All life insurance claims, Accidental Death Benefit Claims, Accidental Dismemberment Claims and Waiver of Life Premium Claims should be sent to:

For Missouri

Anthem Life Insurance Company
Claims Service Center
P.O. Box 182361
Columbus, OH 43218-2361
Phone: **800-813-5682**
Fax: **614-433-8861**

For Wisconsin

Atlanta Life Service Center
P.O. Box 105448
Atlanta, GA 30348-5448
Phone: **800-552-2137**
Fax: **404-682-9255**

Short-term disability benefit claims

To submit a short-term disability claim, the Employer must complete the Employer's Statement portion of the Disability Claim Form, and have the employee complete the Employee's Statement portion.

Failure to complete all questions could delay processing.

- The employee must sign and date the Authorization and Disclosure portion of the Disability Claim Form.
- The employee's physician must complete the Physician's Statement portion of the Disability Claim Form.

The completed Disability Claim Form should be sent to:

For Missouri Disability Claims

Anthem Life Insurance Company
Claims Service Center
P.O. Box 182361
Columbus, OH 43218-2361
Phone: **800-813-5682**
Fax: **614-433-8861**

For Wisconsin Disability Claims

Atlanta Disability Service Center
P.O. Box 105426
Atlanta, GA 30348-5426
Phone: **800-232-0113**
Fax: **800-850-0017**

The initial disability benefit will include all benefits from the date last worked through the current date, Thereafter, we issue disability payments weekly. From time to time, Anthem Life may require a new claim form from the employee and a re-certification of the continuing disability from the employee's physician. We'll supply the form when necessary.

Long-term disability benefit claims

Submit claims for long-term disability benefits to the appropriate Claims Center 30 days before the end of the elimination period. (Refer to the group certificate to determine the length of the elimination period.)

To submit a long-term disability benefit claim:

- · The employee must complete, sign and date the Authorization and Disclosures Form and the Employee's Statement.
- · The attending physician must complete the Physician's Statement. The attending physician must complete all applicable questions and sign and date the statement to avoid any delays in processing.
- · The employer must complete the Employer's Statement and the job analysis sections of the Long Term Disability Claim Form.

Please send the completed Long Term Disability Claim Form, along with a copy of the employee's job description, to:

For Missouri Claims

Anthem Life Insurance Company
Claims Service Center
P.O. Box 182361
Columbus, OH 43218-2361
Phone: **800-813-5632**
Fax: **614-433-8861**

For Wisconsin Disability Claims

Atlanta Disability Service Center
P.O. Box 105426
Atlanta, GA 30348-5426
Phone: **800-232-0113**
Fax: **800-850-0017**

The initial disability benefit will include all benefits due from the date last worked through the current date. Thereafter, we'll issue disability payments monthly.

From time to time, Anthem Life may require a new claim form from the employee and re-certification for the continuing disability from the physician. We will supply the form when necessary.

Appeals

A claim denial may be appealed by the group, the employee or the beneficiary. The appeal must be in writing and should indicate the reason it is believed that the claim decision was incorrect. Any additional documentation of the facts not previously furnished should also be included. The appeal letter should be addressed as follows:

For Missouri Appeals

Anthem Life Insurance Company
Attn: Claims Manager
P.O. Box 182361
Columbus, OH 43218-2361
Phone: **800-813-5682**
Fax: **614-433-8861**

For Wisconsin Life Claims Appeals

WI Life Claims Appeals
Atlanta Life Service Center
P.O. Box 105448
Atlanta, GA 30348-5448
Phone: **(800) 552-2137**
Fax: **404-682-9255**

For Wisconsin Disability Claims Appeals

WI Disability Claims Appeals
Atlanta Disability Service Center
P.O. Box 105426
Atlanta, GA 30348-5426
Phone: **800-232-0113**
Fax: **800-850-0017**

Appendix

Enrollment Guide

ACTION	*Employee Application*	*Employee Change Form Application*	*Employer Application*	*Employee Termination Report*	*Additional Information*
Add new members and/or dependents to the plan.	✔				Additional documentation may be required depending on the type of dependent.
Add dependents for existing members.	✔				Additional documentation may be required depending on the type of dependent.
Add members due to special enrollment (qualifying event).	✔				
Decline coverage for members and/or dependents.	✔				Waiver of Coverage section must be completed.
Benefit changes for members or dependents who already have coverage.		✔			Benefit changes may only be requested on the group's anniversary date.
Terminate members from the plan.				✔	Submit immediately upon termination to Anthem.
Terminate dependents from the plan.		✔			Submit immediately upon termination to Anthem.
Discontinue coverage for members still eligible under the plan.	✔				Eligible employees should complete the employee application to include a waiver of coverage.
Discontinue coverage for dependents still eligible under the plan.		✔			Dependent terminations must be requested on the employee change form only.
Change members' addresses.		✔			Changes can also be done over the phone by the member directly.
Provide notification of a COBRA or State Continuation qualifying event for members and/or dependents already enrolled in the plan.	✔				∘ Reason for Application Section must be completed. ∘ Dependents requesting COBRA or State Continuation must complete the Employee Application.
Change group's address.			✔		You may also submit a written request on the group's letterhead.
Add/change group contact.			✔		You may also submit a written request on the group's letterhead.

Effective dates are determined as follows:

1) New Hire – **For Missouri:** Coverage will become effective the day after the end of the group's service waiting period unless the group elected first bill following the waiting period, provided that the Anthem Enrollment Application is received within the time period stated in the group contract. **For Wisconsin:** Coverage will become effective the first of month following completion of the probationary period.
2) If the application is received by Anthem more than 31 days after the member's eligibility date, the applicant may be considered a Late Enrollee by definition under HIPAA and may only enroll at the group's next open enrollment.
3.) Open Enrollment –
   For Groups 2-50
   - If the application is received by Anthem within the 31 days prior to the group's renewal date, coverage will be effective on the renewal date.
   - If the application is received by Anthem within 31 days after the renewal date, coverage will be effective one month after the renewal date.

   For Groups 51+
   - If the application is received by Anthem within the 31 days prior to the group's renewal date through the 31 days following the group's renewal date, coverage will be effective on the renewal date.

Enrolling Dependents — Application Requirements

Type of Dependent	*Application for coverage must be received:*	*Must include (if requesting coverage):*
New spouse	Within 31 days of marriage	Employee application
Newborn child **For Missouri** **For Wisconsin**	Within 31 days of birth The application for the dependent should be received within 60 days (to avoid late penalties) up to a year (if the member pays past due premiums plus 5-1/2 % interest).	Employee application
Adopted child(ren) **For Missouri** **For Wisconsin**	Within 31 days of adoption Within 60 days of adoption	• Employee application • Court adoption papers
Stepchild	Within 31 days of marriage	• Employee application
Ward of a permanent legal guardian	• Filed within 31 days of issuance of the final court decree or order of legal guardianship.	• Employee application • Letters of guardianship from the court that show the filing date and court seal
Dependent who previously declined coverage	• During the group's open enrollment period • Special enrollment due to qualifying event	• Employee application
Grandchild(ren)	• For Wisconsin only, refer to Changes in Coverage section of the manual for details.	• For Wisconsin only, refer to Changes in Coverage section of the manual for details.

Applications with missing information are considered to be incomplete and may be returned for completion.

Appendix (cont.)

Important Reminders for All Groups

This list provides you with some helpful hints:

- For groups that are age/sex rated, Anthem uses an age/sex rating method where ages fall within a certain band/bracket. Rates will be updated when employees and/or their spouses have birthdays, which take them to the next age band/bracket.
- Effective dates for new employees will be processed as described in the group contract. A summary of the various probationary periods is below.

Missouri — Effective Date: Day after end of Probationary Period

Probationary Period	*Anthem receives application up to 31 days following completion of probationary period, the effective date is:*	*Anthem receives application more than 31 days following completion of probationary period:*
0 days	Day of employment	Wait until open enrollment
30 days	31st day	Wait until open enrollment
60 days	61st day	Wait until open enrollment
90 days	91st day	Wait until open enrollment

*** For Wisconsin – initial eligibility is first of the month following the probationary period, not the first day. Refer to the master contract.**

Effective Date: First billing due date

Probationary Period	*Anthem receives application up to 31 days following completion of probationary period, the effective date is:*	*Anthem receives application more than 31 days following completion of probationary period:*
0 days	1st billing due date after date of hire	Wait until open enrollment
30 days	1st billing due date after the end of the 30-day probationary period	Wait until open enrollment
60 days	1st billing due date after the end of the 60-day probationary period	Wait until open enrollment
90 days	1st billing due date after the end of the 90 days probationary period.	Wait until open enrollment

- Enrollment applications received more than 31 days after the date the probationary period ends will cause those applicants to be considered "late enrollees." Applicants can also become late enrollees if:
  - they were eligible persons or dependents applying for coverage but did not request coverage during a Special Enrollment period.
  - they were newly eligible dependents who failed to qualify during the Special Enrollment period and did not enroll within 31 days of becoming eligible.

The open enrollment period is 31 days prior to and 31 days after the group's renewal date. Late enrollees must wait until the group's next open enrollment period to apply for coverage.

Please refer to your group contract for more detailed information on administering your health benefits.

Glossary of Terms

To help you better understand some of the more complex terms in this manual we created a Glossary of Terms.

Terms and definitions

Certificate — Summary of the terms of the member's benefits. It is attached to and is a part of the group's contract, and it is subject to the terms of the group's contract.

Coinsurance — A percentage of an eligible expense that the member is required to pay for a covered service.

Consolidated Omnibus Budget Reconciliation Act (COBRA) — A federal act, which requires certain group health plans to allow certain employees and dependents to continue their group coverage for a stated period of time. This period of time follows a qualifying event that causes the loss of group health coverage. Qualifying events include reduced work hours, death or divorce of a covered employee, and termination of employment.

Conversion plan — Coverage that may be offered by the terminated member's plan. A conversion plan is an individual contract offered to certain members who lose their group coverage.

Deductible — The dollar amount of covered services listed in the Schedule of Benefits for which the member is responsible.

Dependent — An employee's spouse; employee's or employee's spouse's unmarried children. This includes newborns, legally adopted children, unmarried children who qualify as an eligible dependent as defined in your certificate, or unmarried step-children or children for whom the employee or the employee's spouse is the legal guardian. It also includes children who are covered under Qualified Medical Child Support Orders (QMCSO). For Wisconsin, grandchild(ren) may qualify as a dependent also.

Eligible Employee/Member — To be eligible to enroll an individual must:

- be an employee of the group who is entitled to participate in the benefit plan arranged by the group. The individual must have satisfied any probationary or waiting period established by the group and meet the eligibility criteria stated in the group's contract.
- an employee of the group who is entitled to coverage under a trust agreement or employment contract.

Employee Retirement Income Security Act (ERISA) — A broad-reaching federal law that regulates certain pension plans and employee welfare benefit plans (including certain group health plans).

Explanation of Benefits (EOB) — After the member or the member's provider submits a claim, Anthem will send the member an explanation that will give them the claims payment information. This includes the amount paid to the provider and any amount the member may owe. If a deductible and/or coinsurance applies, the amount applied to the member's deductible and out-of-pocket maximum will also be shown.

Health Insurance Portability and Accountability Act (HIPAA) — Federal legislation passed in 1996 that has multiple requirements, including insurance portability, privacy, security and electronic data requirements.

Limiting Age — The age where a member's dependent child is no longer covered under the member's contract with the group.

Net Eligible Employees — Your eligible employees for health insurance who do not have other group medical insurance, for example, through a spouse.

Next Rx — The prescription drug plan for Anthem Blue Cross and Blue Shield.

Placement Date — The date the member assumes and retains the legal obligation for total or partial support of a child in anticipation of adopting the child with coverage being effective upon such placement

Pre-existing Condition — A condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within six months of the period ending on the member's enrollment date. Pregnancy is not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

Appendix (cont.)

Pre-existing Condition/Waiting Period — An amount of time applied before claims will be paid on a pre-existing condition. Late enrollees may have a longer pre-existing waiting period. Refer to your group's contract for more information.

Primary care physician (PCP) — A family practitioner, general practitioner, internist or pediatrician who provides care and coordinates the member's medical treatment. Network PCPs meet qualification standards and are subject to periodic review.

Probationary Period — A period of time as defined by the group's contract that your employee must meet before becoming eligible for coverage and for becoming a member.

Qualified Medical Child Support Order (QMCSO) — A medical child support order that has been determined by the group to be "qualified" and so to require enrollment of the dependent. Such an order is referred to as a Qualified Medical Child Support Order (QMCSO).

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