



Nevada underwriting guidelines

Small Group services
1-50 employees
Effective January 1, 2025

Table of contents

Important contact information	1
Introduction	2
Section 1 Overview of underwriting process	
1. Requirements for completing forms	3
2. Guidelines for completing forms	3
3. Process	3
4. Processing time specifications	4
5. Evaluation criteria	4
Section 2 General underwriting guidelines for new business	
1. Group eligibility requirements	5
2. Employer/employee relationship	5-6
3. Ineligible categories	6
4. Employer contribution	6
5. Employee eligibility	7
6. Employee participation requirements	7
7. Underwriting	7
8. Health coverage	8
9. Vision coverage	8
10. Dental coverage	8
11. Rating policies	9
12. Rate and benefit guarantee	9
13. New group eligibility/effective date	9
14. Waiting period	8
16 Takeover provisions	9-10
17. Prior deductible credit/annual maximum out-of-pocket credit	10
18. Eligible dependents	10
19. Federal regulations	10-11
20. Nevada business structure underwriting requirements	11
Section 3 General underwriting guidelines for existing business	

1. Open enrollment	12
2. Contract benefit modifications	12
3. Plan modification job aid.....	12
4. Member add effective dates	14
5. Group conversion.....	14

Section 4 Definitions

1. Declination	14
2. Dependent	14
3. Late entrant.....	15
4. New hire.....	15
5. Replacement group/members	15
6. Special enrollment period	15
7. Virgin group/members.....	15
8. Contributory	15
9. Noncontributory.....	15

Important contact information

Small Group Underwriting

Anthem Blue Cross and Blue Shield
9133 W. Russell Road
Las Vegas, NV 89148

Overnight Delivery

Anthem Blue Cross and Blue Shield Small Group Sales
9133 W. Russell Road
Las Vegas, NV 89148
Phone: 1-702-586-6306

Small Group Member Customer Service

Phone: 1-855-330-1218
Hours of operation: Monday – Friday, 6:30 a.m. – 4:30 p.m. PST

Broker Support Team

9133 W. Russell Road
Las Vegas, NV 89148
Phone: 1-855-886-6160
Fax: 1-855-750-2227
Email: nvsgbroker@anthem.com
Hours of operation: Monday – Friday, 8 a.m. – 5 p.m. PST

Broker Portal Technical Support

Phone: 1-888-268-4361
software.support@anthem.com

Group Administrator

Anthem Blue Cross and Blue Shield Membership Department
P.O. Box 172405
Denver, CO 80217-2405
Phone: 1-800-922-4770
Fax: 1-855-750-2227
Email: small.group@anthem.com
Hours of operation: Monday – Friday, 7 a.m. – 4:30 p.m. PST

Anthem Connect (SG Specialty)

Anthem Blue Cross and Blue Shield
Phone: 1-866-956-8602
Fax: 1-877-604-2124
Email: connect@anthem.com

Summary of Benefits and Coverage: <https://plan-summaries.anthem.com/sobdps/>

Producer Toolbox: <https://brokerportal.anthem.com/apps/ptb/login>

Premium Payments:

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

Introduction

This manual provides Anthem Blue Cross and Blue Shield's (Anthem's) current **general** underwriting guidelines for Small Group business.

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

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

These underwriting guidelines have been updated to comply with federal and state requirements, including applicable provisions of the federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes.

Section 1 Overview of the underwriting process

1. Requirements for completing forms

The following documentation is required when submitting new business:

- a. A copy of the agent's quote based on enrollment for current effective date.
- b. The most current *Small Group Employer Application* (master application).
- c. The most current employee applications or census file from all employees/dependents enrolling.
- d. Applications from all employees/dependents declining coverage; Sections B and F of the Employee Application must be completed if declining coverage.
- e. A copy of the company's most recent Nevada Employer's Quarterly Wage and Tax Report* (DETR) which must be justified by showing employee names and indicates whether they are full-time, part-time, seasonal, not yet eligible, terminated or waiving. We will accept either a copy of the official Nevada Employer's Quarterly Wage and Tax Report (DETR) or the "Quarterly Contribution Report Worksheet" provided by the employer's payroll company. Payroll will need to be submitted for any new hire not listed. If hired within two weeks of group application, a W-4 may be submitted. (See page 16 for a listing of alternative forms to validate business and employee eligibility when the Nevada Employer's Quarterly Wage and Tax Report* (DETR) isn't available).
- f. A completed Electronic Funds Transfer (EFT) Authorization Form for 80% of the first month's premium made payable to Anthem Blue Cross and Blue Shield for all applicable lines of coverage. If Electronic Funds Transfer is not agreed to, then a physical company check will be accepted, subject to additional processing time. Check must be imprinted with group name and address for the first month's applicable lines of coverage, made payable to Anthem (**personal noncompany checks cannot be accepted**).
- g. A *1099 Addendum* (applicable for 1099 individuals).

2. Guidelines for completing forms

Use these guidelines for completing *Employer* and *Employee Applications* for groups of 1-50:

- a. Answer all questions and make sure all signatures and dates are included. If the group paperwork is incomplete, our underwriter may not be able to complete the underwriting process.
- b. For new group submissions, the employee's signature date can't be more than 60 days before the requested coverage effective date.
- c. Employees can make changes to their *Employee Application*. They must initial and date any changes they make.
- d. See *section 2*, page 6, for specific guidelines for groups of 1-50 with only one employee enrolling.

3. Process

Underwriters evaluate Small Groups to determine whether the group qualifies for coverage under current state and federal requirements.

4. Processing time specifications

Processing within specific time frames is important. All forms and other documents submitted for evaluation must be completed accurately and included with the case when it is first submitted to Anthem:

- a. We'll accept new group submissions:
 - 1) with a requested effective date of the first of the month up to the last day of the month before the requested effective date, or
 - 2) with a requested effective date of the 15th of the month up to the 12th of the month before the requested effective date.
- b. If we receive incomplete forms, we can't make a determination until we receive all the necessary information.
- c. When the information submitted is incomplete and subsequently not received in a timely manner, we may withdraw the group's application for the month requested.

*Applies to Medical new business only. Not required for Dental and/or Vision stand-alone new business.

5. Evaluation criteria

We base underwriting on the following criteria:

- a. Business qualification
- b. Employer contribution, if applicable
- c. Employee and dependent eligibility
- d. Employee participation, if applicable
- e. Geographic location
- f. Age
- g. Standard industry classification code (applies to dental)
- h. Family size
- i. For employees and dependents residing outside the state of Nevada, members should not enroll on the following networks/products: Pathway PPO, Choice EPO, or any HMO plan. These networks and products do not provide Blue Card benefits for elective medical services. To get benefits for Covered Services, you must use In-Network Providers, unless we have approved an Authorized Service or if your care involves Emergency Care.

We may decline a group if:

- a. A bona fide employer/employee relationship doesn't exist.
- b. At least 50% minimum enrollment does not reside in Nevada. Refer to section 2-1a
- c. The group isn't subject to *NRS 689C* (Nevada Small Group statutes) or if Anthem determines that another state's laws apply to the group's plan.
- d. The group doesn't meet our eligibility requirements.
- e. Other such factors, as determined by Anthem and subject to applicable law, apply.

Section 2 General underwriting guidelines for new business

1. Group eligibility requirements:

- a. At least 50% minimum enrollment must reside in Nevada or at least 50% of the enrolled employees must reside in an Anthem defined service area if the highest number or equal to the highest number of enrolled employees reside in Nevada.
- b. "Small employer" is as defined by NRS 689C.095. A husband-and-wife group with one full-time nonfamilial employee (defined as a full-time employee other than one's spouse) is eligible for Small Group coverage. The nonfamilial employee can waive coverage.
- c. For all organization types: "A registered foreign entity must be headquartered in Nevada, have a physical address in Nevada, meet the definition of a small employer in Nevada and meet all other underwriting guidelines to be eligible for coverage".
- d. For the purposes of determining the number of eligible employees, organizations that are affiliated or eligible to file a combined tax return for the purposes of taxation constitute one employer. Organizations are "affiliated" if one directly, or indirectly, through one or more intermediaries, controls or is controlled by, or is under common control with, the other, as determined pursuant to the provisions of applicable law.
- e. Eligible employee means a permanent employee who has a regular working week of 30 or more hours. The term does not include a sole proprietor.
- f. Per 42 U.S. Code § 18024 (b) (2), the term "small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.
- g. For an employer to qualify for Small Group coverage, the business must have at least one employee who is not the owner or the owner's spouse. Employer is responsible for determining whether it qualifies as a small or large group. Anthem reserves the right to require, audit and confirm the calculations to determine group size.
- h. Seasonal employees — A seasonal employee performs work only during a season and is expected to work less than 120 days, such as a department store during the holidays. For Small Group, seasonal employees are not eligible for health insurance coverage.

2. Employer/employee relationship:

- a. An employer/employee relationship must exist. An employee who works a minimum of 30 hours per week is considered a full-time employee.
- b. Persons that the employer compensates on a 1099 basis are eligible for coverage. Requirements for groups with 1099 contractors are as follows:
 - No more than 50% of the group's insurance enrolled population can be 1099 contractors.
 - All present and future 1099 contractors are subject to the same eligibility requirements as taxed employees.
 - The employer must contribute the same amount for 1099 contractors as for all other employees qualifying under NRS 689C.
 - The employer must have at least two taxed employees, with tax documents that verify the company is a valid business.
 - The new group submission must include a complete list of all 1099 contractors, four weeks of current payment documenting active FT 1099 status, and a completed *Eligibility Requirements Form for Groups Covering 1099 Contractors*.

- c. Temporary, part-time and substitute employees aren't eligible. Seasonal employees aren't (for consistency) eligible, except as specifically provided in these guidelines.
- d. Underwriting will consider accounts with ownership or effective control of greater than 50% for combined rating; however, IRS rules must be followed to determine whether a group is small or large for market reform and MLR and for determination of Medicare primary liability. Companies with common ownership are considered a single group if the companies fall under the definition provided under the Health Insurance Portability and Accountability Act (HIPAA). HIPAA states that all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code shall be considered as one employer. If they are not considered as one employer, then they must be insured/covered separately. It is the group's responsibility to establish with us whether a control group exists by submitting a signed Common Ownership attestation validating common ownership of all companies involved. Documentation can be submitted before the case submission. Underwriting will make the final determination about whether there is one responsible employer.

3. Ineligible categories

Associations (except where eligible by law as a large group), multiple-employer trusts, part-time and seasonal employees, retirees, and board of director members and stockholders aren't eligible for coverage, except as specifically provided in these guidelines. These categories are defined or explained below:

- a. **Multiple-employer trust:** Employers, usually in the same or related industries, brought together by an insurer, agent, broker or administrator to provide insurance for their employees under a master contract issued to a trustee under a trust agreement.
- b. **Part-time employee:** An employee who works on average less than 30 hours per week.
- c. **Retirees:** May be eligible for Medicare Supplement products.
- d. **Board of director members and stockholders:** Not eligible for coverage unless they're also officers of the company and working at least 30 hours per week.
- e. **Hawaii employees:** Those who live or work in Hawaii are ineligible because Anthem is neither a Hawaii-authorized insurer nor a Hawaii Health Care Contractor.

4. Employer contribution

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

Health:

- a. **Traditional option:** A minimum contribution of 50% of each employee's monthly health premium.
- b. **Fixed-dollar option:** A minimum contribution of 50% towards the leanest plan with employee enrollment.
- c. **Percentage-of-plan option:** A minimum of 50% toward a specific plan, chosen by the employer.

Dental:

- a. No employer contribution requirements for voluntary and non-voluntary (employer-paid) plans.

Vision:

- a. No employer contribution requirements for voluntary and non-voluntary (employer-paid) plans.

5. Employee eligibility

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

6. Employee participation requirements

Groups must maintain minimum participation levels to remain eligible (100% if noncontributory) and are subject to nonrenewal if participation falls below the required minimum.

Health:

Standard group participation requirements:

Minimum 75% of eligible employees

Dental:

- a. 2-50 eligible requires 50% participation. Minimum of two employees must enroll.
- b. Voluntary dental requires minimum of five eligible employees. Minimum of two employees must enroll.

Vision:

Standard group participation requirements:

- a. Minimum 50% of eligible employees with a minimum of two enrolled when employer offers vision coverage on a stand-alone basis or with health coverage.
- b. Minimum of 5 eligible employees for voluntary vision plans with a minimum of two enrolled when employer offers vision coverage on a stand-alone basis or with health and/or dental coverage.
- c. Cannot combine a voluntary vision plan with an employer sponsored vision plan.

Dual option participation requirements:

- a. Employer-Paid Vision: minimum of 10 net eligible employees. Two or more employees must enroll in each plan with at least 50% of net eligible enrolling.
- b. Voluntary Vision: minimum 10 net eligible employees. Two or more employees must enroll in each option.

7. Underwriting

We'll underwrite groups of 1-50 according to Nevada laws and regulations, including the criteria outlined in *NRS 689C*:

- a. Eligible employees and their dependents waiving coverage at the time of enrollment must complete a waiver of coverage, which includes sections B and F of the Employee Application and submitting the completed forms to us. We may also require proof of coverage.
- b. If a husband and wife both work for the same employer, they may apply separately as employees, or one may be a dependent on the other's coverage. The children may apply as dependents of only one employee, not both. This applies to all lines of coverage.
- c. Class carve-outs such as management only or salary vs non-salary may be considered with underwriting approval. A list of the job classifications the employer wants to insure will be required with the initial group submission. All employees must be accounted for, and those in the carved-out classification must be identified. These carve-out groups are subject to underwriting approval and may be declined if they do not meet Anthem's underwriting criteria.

8. Health coverage

- a. Employers may offer any combination of plans or networks.
- b. The portfolio includes PPO, Pathway PPO, Choice PPO, Choice EPO, Link HMO/PPO, Convenient Care HMO and Guided Access HMO.

9. Vision coverage

- a. No waiting periods.
- b. Vision coverage is available to groups of 2-50. A minimum of two subscribers must enroll.
- c. Employers may select a maximum of two plans.
 - Dual Option requires at least 10 net eligible employees. Two or more employees must enroll in each option.
 - Voluntary Dual Option requires at least 10 net eligible employees. Two or more employees must enroll in each option.

Cannot combine a voluntary vision plan with an employer sponsored vision plan.

- d. Pediatric vision coverage is included in all ACA-compliant medical plans.

10. Dental coverage

- a. Essential Choice dental plans are available for groups of 1-50 with a minimum of two employees enrolling.
- b. Dual option is available if the group has at least 15 net eligible employees. A minimum of 5 employees must enroll in each option with a 10% premium differential.
- c. Dual option is not available for voluntary plans.
- d. Group must be headquartered in Nevada.
- e. Groups with 50% or more of eligible employees residing outside the state are subject to Underwriting review.
- f. Cannot accept SIC codes 9999 or 8021 (Dental offices and clinics aren't eligible).
- g. Coordination of benefits applies.
- h. Medlock feature is available. Enrollment elections for Anthem medical and Anthem dental must be the same (for example: employee only on medical, dental must be employee-only). Medlock does not apply to voluntary dental.
- i. Optional orthodontic coverage is available for employer paid Classic and Enhanced plans and Voluntary plans:
 - Requires five or more employees to be enrolled.
 - Employer paid: no orthodontic waiting periods for new groups or new hires.
 - Employer paid: coverage options are for child-only orthodontic coverage for dependents age 8 through 18 or adult and child orthodontic coverage from age 8.
 - Voluntary plans have single dependent option, child (age 8-18) only
- j. Maximum carry-over provision is included on all plans except for unlimited maximum benefit dental plans.
- k. Unlimited maximum benefit dental plans require 10 eligible employees for quoting; 50% of employees eligible must enroll.

11. Rating policies

- a. Rates are based on the group's actual enrollment with exception of dental and vision which are based on total number eligible.
- b. Underwriting will determine the group's acceptance, final rates and effective date.
- c. Member rating or two-tier composite rating is available to any medical group upon request.

For member rating, Employer pays a per Subscriber per month fee calculated by adding the sum of the rates for each of the Member categories (Subscriber, Spouse, up to three oldest Dependents 20 years and younger, and Dependents 21 years and over). Change in age affecting a member's premium will see the premium change occur at the group's renewal date.

For composite rating (two-tier), Employer pays a per Subscriber per month fee calculated by adding the sum of the rates for each of the Member categories. Composite premiums are based upon the average adult premium for those individuals enrolling ages 21 and over. The dependent composite rate is based on the average premium for those enrolling under the age of 21.

12. Rate and benefit guarantee

- a. We may change health plan rates and benefits with a 60-day advance written notice or, when the change is mandated by law, without advance notice.
- b. Health plan rates are guaranteed for a maximum of 12 months.
- c. Dental Essential Choice rates are guaranteed for either 12 or 24 months.
- d. Vision rates are guaranteed for 24 months.

13. New group eligibility/effective date

- a. The eligibility date for existing employees and dependents is the employer's effective date unless new hires haven't yet satisfied their employer's waiting-period requirements. The effective date for these employees will be the first of the month after their completed Enrollment Application is submitted.
- b. Employers can waive the waiting period for all new hires when the group initially enrolls.
- c. Employer groups of 1-50 aren't guaranteed an effective date.
- d. The small group underwriter will determine the group's acceptance, final rates, and effective date.

14. Waiting period

Employers may designate their waiting period as follows:

First of the month following the employee's hire date, first of the month following one month from date of hire, or first of the month following two months from date of hire. A future employee's coverage eligibility date is always the first day of the month following completion of the waiting period. **Anthem will not waive the waiting period for any future employees.**

15. Takeover provisions

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

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

If an employer obtains a replacement policy to cover his or her employees, any benefits provided by the previous policy or coverage may be reduced if notice of the reduction is given to his or her employees. Any insurer who issues

a replacement policy may submit a written request to the insurer who provided the previous policy or coverage for a statement of benefits that were provided under that policy or coverage. Upon receiving such a request, the insurer who provided the previous policy or coverage will give a written statement to the insurer providing the replacement policy that indicates what benefits were provided and what exclusions or reductions were in effect under the previous policy or coverage.

The provisions of this section apply to a self-insured employer who provides health benefits to his employees and replaces those benefits with a policy of group health insurance but do not apply to the Public Employees' Benefits Program established pursuant to *NRS 287.0402 to 287.049*: leg.state.nv.us/Nrs/NRS-287.html.

16. Prior deductible credit/annual maximum out-of-pocket credit

- a. For new group submissions, we provide credit for deductibles met under prior group health coverage, if proof of the actual dollar amount is submitted with the first claim or before 180 days, whichever comes first.
- b. We provide credit for deductibles met under our group health plans.
- c. We do not provide credit for pharmacy deductibles.
- d. We do not provide credit for annual maximum out-of-pocket.
- e. We do not provide credit for deductibles met under our dental plans.
- f. We do not provide credit for claims incurred prior to the Anthem benefit period.

17. Eligible dependents

Dependent coverage is available to the following:

- a. Lawful spouse/domestic partner
- b. Natural child
- c. Newborn child
- d. Legally adopted child
- e. Stepchild
- f. Ward of legal guardian
- g. Grandchild of eligible dependent if the subscriber is the permanent legal guardian; otherwise grandchildren are covered only to the extent required by law
- h. Other such classifications, as required by law or regulation

See *section 4, "Definitions,"* for specific age criteria.

18. Federal Regulations

- a. *Federal Tax Equity and Fiscal Responsibility Act* (TEFRA), *Deficit Reduction Act* (DEFRA) and COBRA legislation regulate employee health care coverage. Based on this legislation and our agreement with the employer, if a business employs, on average, fewer than 20 employees in a year and any employee turns 65 years of age, his or her primary health insurance carrier will be Medicare. For employees who are at least 65 years old and who choose to keep their Anthem coverage, we'll be a secondary carrier for Medicare benefits paid or payable.
- b. If a member is covered by Medicare and Anthem, and we're secondary to Medicare, the Medicare payment is calculated first and we coordinate up to 100% of coverage for deductibles and coinsurance, not to exceed the Anthem benefit.

Special Coordination of Benefits (COB) rules may apply, specifically for Medicare secondary payer situations. The group's *Certificate* contains additional details about COB rules.

- c. Anthem is secondary to Medicare when one of the following criteria are met:
 - The employer has fewer than 20 employees and the member is at least age 65.

- The employer has fewer than 20 employees and the member under age 65 is eligible for Medicare due to a disability.
- The member enrolled following the first 30 months of kidney dialysis treatments for end-stage renal disease.

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

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

19. Nevada business structure underwriting requirements

*Documentation requirements for each business type		
Business type	In business more than 3 months	In business less than 3 months
C Corporation	<i>Nevada Employer's Quarterly Contribution and Wage Report</i>	Payroll records and <i>Articles of Incorporation</i>
S Corporation	<i>Nevada Employer's Quarterly Contribution and Wage Report*</i> or K-1 for shareholder's income	Payroll records and <i>Articles of Incorporation</i>
Partnership	K-1 for partner's income or <i>Schedule SE</i> (self-employment tax) or <i>Form 1065 Partnership Return</i> and <i>Nevada Employer's Quarterly Contribution and Wage Report</i> for employees	<i>Partnership Agreement</i> and SS-4 (application for tax ID) and payroll records
Limited liability company (LLC)	May file as either a C Corporation or a Partnership (refer to above)	May file as either a C Corporation owner or a Partnership (refer to above)
**Sole proprietorship	<i>Schedule SE</i> and <i>Schedule C</i> filed <i>Form 1040</i> (tax return) and <i>Nevada Employer's Quarterly Contribution Report</i> for salaried employees	Payroll records and SS-4 or appropriate tax ID verification. A sole proprietor can use a Social Security number instead of getting a new tax ID number
Independent contractor	Signed <i>1099 Addendum Form</i> , a complete list of all <i>1099</i> contractors, and four weeks of current payment documenting active FT <i>1099</i> status.	Signed <i>1099 Addendum Form</i> , a complete list of all <i>1099</i> contractors, and four weeks of current payment documenting active FT <i>1099</i> status.
Farm	<i>Form 1040</i> and <i>Schedule F</i> or K-1. Farms can also file <i>Form 1041</i> , <i>1065</i> or <i>1065B</i>	Payroll records and SS-4 or <i>Articles of Incorporation</i> , <i>Partnership Agreement</i> , etc.
Nonprofit organization	<i>Form 940</i> or <i>Form 990</i>	<i>Articles of Organization</i> and IRS confirmation of nonprofit status

Startup group	N/A	Payroll records, business license and <i>Articles of Incorporation</i> Note: We can't accept a brand new business until payroll records are available.
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*Applies to Medical new business only. Not required for Dental and/or vision stand-alone new business.

**Effective January 1, 2014 new non-qualified sole proprietors are not allowed in Small Group, example: an employer with no employees other than the owner's spouse. A sole proprietor is defined by the ACA as an employer with no common law employees who work enough hours to be eligible for coverage. Children of employers are considered to be common law employees, regardless of their age.

A husband-and-wife group with one nonfamilial employee (a full-time employee other than one's spouse) is eligible for Small Group coverage. The nonfamilial employee can waive coverage.

All groups must be registered with the Nevada Secretary of State.

Section 3 General underwriting guidelines for existing business

1. Open enrollment

An employee and/or qualified dependent who previously declined coverage and later wants to enroll may apply at open enrollment. Special enrollment periods may apply. See section 4, "Definitions," "Special enrollment period."

2. Contract benefit modifications

Employer level changes

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

The additional criteria below apply to employer level contract benefit modifications:

- Underwriting must receive completed paperwork from groups requesting a benefit modification before the requested effective date. We don't accept requests for retroactive benefit modifications.
- Dental and/or vision added to an existing health plan policy will default to the health rate guarantee after the initial vision rate guarantee expires.
- Subject to Underwriting approval, existing groups can only change their contribution method six months after the original effective date and once in a 12-month period.
- The group cannot change its anniversary date, except as specifically approved by Anthem in writing.
- We must be notified about business ownership or tax ID number changes. These changes are subject to Underwriting review.
- Changes to our products or portfolios don't constitute a new rate and guarantee period.
- If Employer attests that they are a large group, their small group coverage will terminate at the end of the current contract period.

Employee level changes

Covered employees may move to a different plan offered by their employer on the anniversary month of the group's original effective date, or when we approve an employer level benefit change.

An employee requesting a change in health plan coverage must submit the appropriate *Employee Enrollment Application /Change Form for Small Groups 1-50*, if the employer is offering the plan requested.

3. Plan modification job aid

For current Anthem applications and forms, go to [anthem.com](https://www.anthem.com).

Benefit modification	When eligible	Documents necessary
Increasing number of or changing plans offered under medical coverage	On anniversary date	<i>Renewal Change Form</i> (from renewal output)
Change plans or networks	Off anniversary	Complete <i>Nevada Small Group Anniversary Date Change Request Form</i> Note: By requesting this change a group's anniversary month will change. Employers should consult their tax and legal advisors as this change may impact the group's plan year. Request can only be made six months after the original effective date, once in a 12-month period (on an exception -basis only). New rates and benefits may apply.
Add Dental	First of the month following receipt of all documentation	<i>Specialty Benefit Modification Form</i> Census file or enrollment applications for new enrollees Rate proposal
Add Vision	First of the month following receipt of all documentation	<i>Specialty Benefit Modification Form</i> Census file or enrollment applications for new enrollees Rate proposal
Add domestic partner coverage	First of the month following receipt of all documentation	Letter from group <i>Affidavit of Domestic Partnership</i> from applicant
Change in ownership Underwriting will determine if group can maintain current contract or will need to apply as a new group.	First of the month following receipt of all documentation	Letter from group Legal documentation to support buyout, sale of assets, or merger/acquisition.
Change in contribution option	Six months after the original effective date, once in a 12-month period	Letter from group
Change in waiting period	Six months after the original effective date, once in a 12-month period	Letter from group Note: Change will affect future (not current) employees

Benefit modifications are subject to Underwriting approval.

4. Member add effective dates

- a. Eligible employees may apply for coverage for themselves and their eligible dependents by submitting a completed Employee Enrollment Application. Effective dates are determined as follows:
 - We must receive the application within 31 days after the date of hire or within 31 days of the expiration of the employer's waiting period.
 - If we receive the application before the employee's waiting period is completed, the effective date will be the same as the eligibility date or within 31 days of the expiration of the employer's waiting period.
 - If we receive the application more than 31 days after the employee's eligibility date, the applicant is considered a late entrant.
 - **Late Entrant Policy:** Late entrants may enroll only during the employer's annual open enrollment period.
- b. Any time an employee or dependent becomes eligible but doesn't enroll, or if the employee or dependent remains eligible but isn't keeping coverage, sections B and F of the Employee Application must be completed and submitted.
- c. Special enrollment periods are available for newborn children, adopted children, new spouses, and wards of legal guardians*. Generally, they can be added without a waiting period if they are enrolled within 31 days of becoming eligible. In addition, spouses who are eligible, but not enrolled, can also be added in the event of a birth or adoption. An employee who is eligible, but not enrolled, can enroll at the time of marriage, birth, adoption, or placement for adoption*, which are qualifying events.

5. Group conversion

Due to changes in Nevada law, members of terminated health plans who qualify for group conversion plans, and individuals whose COBRA or Nevada State Continuation coverage has expired, are no longer eligible for a *Conversion Benefit Agreement*.

Section 4 Definitions

1. **Declination** — A declination is a formal notification to Anthem that an employee and/or any of the employee's eligible family members are declining or refusing any coverage. The employee must complete sections B and F of the *Employee Application*. A completed declination is required for eligible employees and their dependents who don't enroll when they become eligible.

This information is required to ensure compliance with federal and state laws.

2. **Dependent** — Not all dependent classifications are included within every benefit plan. See the terms of the group's membership Certificate and the group's eligibility rules for additional details. Dependent means a spouse, child under 26 years of age, or an unmarried child of any age who is medically certified as disabled and dependent on the parent:
 - a. A new spouse or stepchild must complete an application.
 - b. An adopted child must be added within 31 days following the date of acceptance of legal responsibility or placement in the physical custody of the adopting parent. Copies of legal documentation must be submitted along with the enrollment.
 - c. Coverage for newborns is automatic only for the first 30 days following birth. Employees must request enrollment of newborns by completing an Employee Application within the first 60 days following birth. Otherwise, coverage terminates at the end of the 31-day period. Refer to Group Administrator Manual, Nevada Small Group Employers (1-50) for additional information.
 - d. A ward of a legal guardian must be added to an existing policy within 31 days following acquisition.

- e. An application must be filed within 31 days of issuance of the final court decree or order of permanent legal guardianship. A *Letters of Guardianship Form* from the court, showing the filing date and court seal, must also be filed with the application.
- f. A grandchild of an eligible dependent is only eligible for coverage within 31 days after the date of birth, unless the subscriber is the permanent legal guardian of the grandchild.

An eligible employee may be required to provide proof of parenthood and dependency of the child. Proof of parenthood must be provided by submitting the child's birth certificate.

- 3. **Late entrant** — A late entrant is an eligible employee or dependent who has declined enrollment in a health plan offered by the employer during the initial enrollment period provided under the terms of the health plan, and who later wants to enroll in a health plan of that employer, if the initial enrollment period is a period of at least 31 days. This also applies to new hires throughout the policy year who have declined coverage and are outside the 31-day window.
- 4. **New hire** — A new hire is an employee in an employer group who is hired after the group's coverage effective date.
- 5. **Replacement group/members** — These are all eligible employees/dependents of an employer group who were covered as a group by a prior carrier.
- 6. **Special enrollment period** — We do not consider an eligible employee or dependent a late entrant if the individual meets the criteria under a, b or c below:
 - a. He or she was covered by another health plan at the time the individual was eligible to enroll.

He or she certified at the time of the initial enrollment that coverage by another health plan was the reason for declining enrollment, provided that, if the individual was covered by another health plan, the individual had the opportunity to make the certification and was notified that failure to do so could result in later treatment as a late entrant.

He or she has lost or will lose coverage under another health plan due to termination of employment of the individual or of a person through whom the individual was covered as a dependent; change in employment status of the individual or of a person through whom the individual was covered as a dependent; termination of the other plan's coverage; cessation of an employer's contribution toward an employee's or dependent's coverage; death of the person through whom the individual was covered as a dependent or; or divorce.

He or she requests enrollment within 31 days after termination of coverage or employer contribution toward coverage provided by another health plan.
 - b. A court has ordered that coverage be provided for the spouse or minor child under a covered employee's health plan, and enrollment is requested within 31 days after the court order is issued.
 - c. We can't produce a written statement from the employer stating that, before declining coverage, the individual or the person through whom the individual was eligible for dependent coverage was provided with and signed an acknowledgment of receiving an explicit written notice in boldface type explaining that failure to elect coverage during the initial enrollment period allows us to exclude coverage for 12 months.
- 7. **Virgin group/members** — These are all eligible employees/dependents of an employer group who have not, as a group, had prior group coverage within the 63 days before the effective date. The probationary period may be waived.
- 8. **Contributory** — The employer pays less than 100%; therefore, the employee must pay a portion of his or her premium.
- 9. **Noncontributory** — The employer pays 100% of the employee's premium.

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