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2023

Benefits Administrator

OFFICE GUIDE

BusinessEDGE®

5-250 Total Employees

OptimaHealth

BENEFITS ADMINISTRATOR OFFICE GUIDE

Business*EDGE*®
(5–250 ENROLLING EMPLOYEES)

January 2023

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INTRODUCTION

At Optima Health, it is our privilege to partner with you to provide quality healthcare to your employees. Each day we strive to make it easier to do business with us through new technologies and simplified processes, while never losing sight of exemplary customer service. Our team focuses on the market to ensure we continue to offer the best healthcare solutions, especially as the economy changes. We appreciate the trust you place in us.

This Guide serves as a convenient reference on general administrative topics such as eligibility, enrollment, membership changes, primary care physician changes, continuing coverage, and group billing. Specific questions regarding group billing, eligibility, and enrollment documents should be directed to the Account Services Department. The Account Services Department is available Monday through Friday, 8:00 a.m. to 5:00 p.m. and may be reached by dialing 757-687-6400 or toll-free at 1-866-472-5764.

The Optima Health website, optimahealth.com, and the Optima Health mobile app also serve as valuable resources for employers and employees. Both the app and the website allow registered members to perform a number of secure transactions within the health plan, including the ability to request member ID cards, view claims, and look up treatment costs in addition to benefit, health plan, and general health-related information. You may visit the website 24 hours a day, 7 days a week.

This Guide is for general administrative purposes only. It is not a contract or policy. The Evidence of Coverage or Certificate of Insurance—the Plan's legal documents—will prevail for all benefits, conditions, limitations, and exclusions.

Thank you for choosing Optima Health. We look forward to serving you and your employees in the months and years to come.

Optima Health
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Business*EDGE*® (5–250 enrolling employees) Enrollment Guidelines

Segment Determination

The following two-step process is used to determine group segmentation.

1. How many total employees (full time and part time) does the group have?
    a. if 50 or fewer, it is a small group and not medically underwritten
    b. if 51 or more, see #2 below
2. If 51 or more total employees, how many are eligible for group coverage?
    a. if fewer than 251 are eligible, the group is mid-market and underwritten
    b. if 251 or more are eligible, the group is underwritten in large group

Employers, Employee, and Dependent Eligibility

Eligible Employers

- corporations, partnerships, or sole proprietorships with a clear employer/employee relationship (1099 employee relationships and disabled workers are not eligible for group coverage)
- for Business*EDGE*®: financially stable business organizations with 5–250 total employees (including owners and partners), and has 5–250 enrolling employees; employers/companies who have not declared bankruptcy or exited bankruptcy in the last five years
- employers with a payroll-deduction system established for employee contributions
- groups that file a Virginia Employment Commission (VEC) Quarterly Wage and Earnings Reports
- employer groups not formed for the sole purpose of securing insurance
- employer groups located within the Optima Health service area
- employer groups that have been in business for at least one year
- carve-outs may be allowed and are subject to nondiscrimination rules and policies

Optima Health must be the only group healthcare coverage offered to all employees. Optima Health must be the only healthcare option offered to the local employees of a national company.

An employer group who would otherwise be eligible for coverage under an Optima Health Group Plan may nonetheless be ineligible if offering coverage to that employer group would cause Optima Health to violate any of its policies for doing business with or providing services to a person who appears on any official sanction list maintained by local, state, or federal government agencies.

Eligible Employees

An employee is eligible for coverage if they:

- are employed by the group
- reside or work in the service area or is an out-of-area employee (and no more than 35% of the eligible and enrolled employees are out-of-area)
- are at least 17 years of age, work at least 30 hours per week, and work and receive a salary for 50 weeks or more per year
- are a U.S. citizen who possesses a Social Security number
- are a legal alien who has possession of a green card as well as a Social Security number

- are within 31 days of the date of initial eligibility and file a complete enrollment application, including any applicable premium or fees, with the Plan
- do not knowingly give incorrect, incomplete, or deceptive information regarding their eligibility for coverage or health history to the Plan or to the employer group
- do not knowingly give incorrect, incomplete, or deceptive information regarding their dependent's eligibility for coverage or health history to the Plan or to the employer group
- meet any other requirements as specified herein, or as specified by the Plan or by the employer group

The employee must appear on the employer's most recent Virginia Employment Commission (VEC) Quarterly Report. Employers must provide proof of true and active employee status for employees not listed (new hires, owners) on the most recent VEC Quarterly Wage and Earnings Report.

Groups with employees that are earning a minimum wage and who are not considered full-time employees must submit the employees' hourly wages with the number of hours they work per week and their job description.

Groups employing both spouses (including same-sex spouses) on a full-time basis should write them as an employee with spouse with the older written as the employee. If both appear on the VEC Quarterly Wage and Earnings Report as full-time employees, they can be added on as separate employees.

Proprietors, directors, or partners of a company are not excluded, provided they meet the criteria listed above. Any other group not required or able to submit a VEC Quarterly Wage and Earnings Report will be required to submit one or all of the following:

- declaration letter attesting to the fact that they meet the above-listed criteria
- list of all current employees and social security numbers
- copy of business license
- papers of incorporation listing principals/officers of the company
- partnership agreement
- W2 form (if applying for coverage at year-end and prior to next quarterly VEC reporting)
- 1040 Schedule C or F
- IRS Schedule K1 (Form 1065 or 11205) or IRS Form 1120
- payroll summary

Out-of-Area Employees

Employees who reside and work outside of the service area or spend more than 90 consecutive days for business purposes outside of the service area, can be included in the quote. No more than 35% of the covered employees can be covered outside of the service area. If more than 35% of the group's covered employees are outside of the service area, the group will either be quoted without the OOA employees or Optima Health will be unable to provide a quote for the entire group.

The networks used for the PPO products, which provide access to in-network providers, are the OHIC PPO network and a contracted national provider network. Members who access care through the participating PPO network providers will be eligible to receive care for covered services at the In-Network benefit level of their PPO plan.

Employees NOT Eligible

- independent contractors (1099) of the employer

- part-time employees who work less than the minimum hours required by the Plan or the employer, which cannot be any less than 25 hours per week; or leased, temporary, or seasonal employees
- directors and officers not otherwise eligible as active, full-time employees
- retirees or pensioned employees

A person who would otherwise be eligible for coverage may nonetheless be ineligible if that person could cause Optima Health to violate any of its policies for doing business with or providing services to a person who appears on any official sanction list maintained by local, state, or federal government agencies.

Eligible Dependents

- legal spouse of the insured employee
- domestic partner
    - have shared a continuous committed relationship with each other for no less than 6 (six) months
    - are jointly responsible for each other's welfare and financial obligations
    - Reside in the same household
    - are not related by blood to a degree of kinship that would prevent marriage from being recognized under the laws of their state of residence
    - each is over age 18, or legal age of consent in your state of legal residence, and legally competent to enter into a legal contract
    - neither is legally married to or legally separated from, nor in a domestic partnership with, a third party
- children up to the end of the month (EOM) in which they turn age 26. Eligible children include:
    - natural or stepchildren
    - foster children
    - legally adopted children
    - children placed with the subscriber for adoption
    - other children for whom the subscriber is a court-appointed legal guardian, including grandchildren.

The Plan will not deny or restrict eligibility for a child who has not attained age 26 EOM based on any of the following:

- financial dependency on the subscriber or any other person
- residency with the subscriber or any other person
- student status
- employment status
- marital status

The Plan will not deny or restrict eligibility of a child based on eligibility for other coverage.

Eligibility to age 26 EOM does not extend to a spouse of a child receiving dependent coverage. Eligibility to age 26 EOM does not extend to a child of a child receiving dependent coverage unless grandchildren are eligible under the terms of the Plan or if the subscriber has legal custody of the grandchild.

Unmarried dependent children (as defined above) over age 26 EOM who are both (i) incapable of self-sustaining employment by reason of mental or physical disability, and (ii) chiefly dependent upon the insured employee for support and maintenance will continue to be eligible for coverage. The insured employee must give the Plan acceptable proof of incapacity and dependency within 31 days of the child's reaching the specified age. Proof of incapacity consists of a statement by a licensed psychologist, psychiatrist, or other physician stating the dependent is incapable of self-sustaining employment by reason of disability from mental or physical disability. The Plan may require subsequent statements not more than once a year.

Out-of-Area Dependents

PPO Plans: The networks used for the PPO products, which provide access to in-network providers, are the OHIC PPO network and a contracted national provider network. Dependents and spouses who access care through the participating PPO network providers will be eligible to receive care for covered services at the in-network benefit level of their PPO plan.

HMO and POS Plans: Through the Out-of-Area Dependent Program, dependent children who reside outside of the Plan's service area can receive in-network benefits through the contracted national provider network. Pre-Authorization applies as necessary.

Employees with dependents on an HMO or POS plan who reside out of the service area must complete an annual proof of eligibility form to receive in-network benefits from contracted national providers.

Dependent children who reside within the Plan's service area and temporarily travel outside of the service area are not covered by the program. Spouses are not covered by this program.

Dependents NOT Eligible

- dependent children over age 26 EOM, unless incapable of self-support due to a disability
- any spouse or child who is insured as an employee of the same employer
- grandchildren for whom the employee does not have legal custody
- individuals no longer legally married to an eligible employee
- any spouse or children for whom the employee has waived coverage

Dependent Verification

Optima Health may, on the employer's behalf, require verification of dependent status from the group or insured employee (subscriber) at any time prior to or after coverage is effective. The following are the most common forms of verification:

- birth certificate
- marriage certificate
- adoption certificate or proof of placement
- custody papers

Dependents enrolling in an Optima Health plan with a last name different from the last name of the subscriber may receive a letter requesting supporting documentation, as listed above. If requested, members will have 45 days to provide this documentation, or they may be dis-enrolled from the Plan.

Optima Health reserves the right to request or review at any time, at its sole and absolute discretion, proof of eligibility of any subscriber or dependent enrolled in the Plan. Should Optima Health discover at any time that any subscriber or dependent is not eligible for coverage, was never eligible to be enrolled

for coverage, and/or submitted false proof of eligibility for coverage, Optima Health may, at its sole discretion, either:

- Retain the premium paid on behalf of the ineligible subscriber/dependent up until the date they became aware of the ineligibility and cancel the subscriber's/dependent's coverage after the date through which premiums were paid.
- Refund the premium payment made on behalf of the subscriber/dependent during the period of ineligibility to the group, dis-enroll the subscriber/dependent, and retract all or part of any claims paid from the provider(s) during the period of ineligibility. Dis-enrollment of a subscriber or dependent due to ineligibility for coverage may result in the reversal and/or denial of claims during the period of ineligibility. The subscriber/dependent may be held responsible by the provider(s) for any charges for claims for services received during the period of ineligibility.
- Refund the premium payment made on behalf of the subscriber/dependent during the period of ineligibility to the group and dis-enroll the subscriber and/or dependent. The subscriber/dependent will be held responsible for any charges for claims for services received during the period they were not eligible to receive services. Optima Health may seek to recover from the member usual and customary charges for any claims paid by the Plan for services received during the period of ineligibility.

Member Plan Changes

Members may only enroll for benefits, or change benefit plans, once per year during the group's established open enrollment period or during a special enrollment period. The group's open enrollment period can be no greater than 60 days prior to the group's anniversary date, and all member enrollment/change applications must be signed no later than the end of the renewal month, or earlier if required by the group.

Members that request initial enrollment or changes from one plan to another, outside of the group-established open enrollment period, must meet the following standard criteria:

- eligibility after completion of new hire waiting period
- loss of coverage under another plan
- reduction in hours
- reasons defined by Section 125 guidelines
- health Information Portable Care Act of 1996 (HIPAA) Special Enrollment Provisions

NOTE: If the group has a current Section 125 plan in place, the criteria specified in that document will apply, in place of the above list.

HIPAA Special Enrollment Provisions (Qualifying Life Events)

The Plan provides special enrollment periods of 60 days from the date of a triggering event for qualified employees or dependents of qualified employees. Those triggering events are:

- qualified individual or dependent loses minimum essential coverage
- qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption
- qualified individual becomes a U.S. citizen, a national or lawfully present individual

The Plan provides special enrollment periods of 30 days from the date of a triggering event for qualified employees or dependents who:

- Become eligible for assistance with respect to coverage under a SHOP under such Medicaid or CHIP plan (including any waiver or demonstration project conducted under such plan).
- **Special enrollment for employees and dependents that lose eligibility under Medicaid or CHIP coverage.** The employer is required to provide employees notice of special enrollment rights and premium assistance under CHIP. Employees or Dependents who are eligible for group coverage will be permitted to enroll late if they (1) lose eligibility for Medicaid or CHIP coverage or (2) become eligible to participate in a premium assistance program under Medicaid or CHIP. In both cases the employee must request special enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

Effective Date of Coverage

Subject to the Plan's receipt of a Business***EDGE*** Group Application for Self-Funded Program and any applicable premium, as determined in accordance with the Group's terms of proration, if any, from or on behalf of each prospective member, coverage shall become effective on the earliest of the following dates, unless otherwise specified by the group on the application.

- **Effective Date of Coverage.** Coverage under this agreement for a subscriber eligible for coverage on the initial effective date of this agreement becomes effective on the effective date of the agreement.
- **Multiple Coverage.** A subscriber is not eligible to be the subscriber on more than one policy with the Plan even if they are connected with more than one participant employer. Such a subscriber will be considered as an employee of one participant employer.
- **Eligible Dependents.** A subscriber's eligible dependent(s), as defined herein, are covered under this agreement only if the subscriber enrolls each dependent as a dependent. Coverage under this agreement for eligible dependents will become effective on the latter of: (i) the date the subscriber's coverage becomes effective; or (ii) on the date the subscriber acquires eligible dependents, provided notification to the Plan is within enrollment guidelines and the required premium has been paid on their behalf.
- **Subscriber Coverage—Addition to an In-Force Plan**
    - When a person completes an Employee Enrollment Application for coverage on, or prior to, the date they satisfy the eligibility requirements above, coverage shall be effective as of the first of the month following the date eligibility requirements are satisfied.
    - When a person completes an Employee Enrollment Application for coverage after the date they satisfy the eligibility requirements above, coverage will be effective as of the first day of the calendar month following the month in which such application is received by the Plan.
- **Newborn Children.** Newborns will be covered from the moment of birth for 30 days, if the subscriber's coverage under the Plan is in effect. In order for coverage to continue beyond 30 days, the subscriber must add the newborn to their coverage within 30 days of birth. An adopted child whose placement has occurred within 30 days of birth will be considered a newborn child of the subscriber, as of the date of adoptive or parental placement. If the newborn is not added to the Plan within 30 days of birth, the newborn may not be eligible to enroll until the next Plan open enrollment period.
- **Adopted or Foster Children.** An adopted or foster child will be eligible for coverage from the date of placement with an eligible subscriber for the purpose of adoption or foster care. An adopted child whose placement has occurred within 30 days of birth will be considered a newborn child of the subscriber as of the date of adoptive or parental placement. Evidence of placement and any applicable premiums must be submitted to the Plan within 30 days from the date of placement. If the adopted or foster child is not added to the Plan within 30 days of placement the child may not be eligible to enroll until the next Plan open enrollment period.
- **Coverage Mandated by Court Order.**
    - If an employer is court ordered by a Qualified Medical Child Support Order (QMCSO) to provide healthcare coverage for a dependent, and the employee does not currently carry

healthcare coverage, the Plan will allow both the employee and court-ordered dependent to enroll within 30 days of the date of the court order (with proper documentation), provided the employee has met their eligibility period.

- The effective date may be the first of the month following receipt of the court order by the Plan Administrator, or the date the Plan Administrator notified the state on the "Employer Response Page" that is returned to the state. The group must attach a copy of the Employer Response Page with the court order. If allowed to enroll in healthcare coverage, the employee must enroll the dependent.
- If an employee is court-ordered to provide medical coverage for a dependent, including a spouse, Optima Health will allow the employee and the dependent to enroll in the plan if enrollment documentation is received within 30 days of the court order date. If the enrollment request is not received timely, the employee will not be able to add the dependent until the group's next Plan open enrollment period.

- **Medicare.** A covered person, who is eligible to be covered under Medicare (Title XVIII of the Social Security Act of 1965, as amended), is encouraged to enroll in Parts A and B coverage on the date they are eligible. If they are under age 65, entitled to Medicare because of End-Stage Renal Disease (ESRD), and have employer group health coverage, the covered person should contact the Plan regarding participation with Medicare Part B or assistance in obtaining Part B.
- **Part-Time to Full-Time Status Change.** Coverage of employees whose employment status changes from part-time to full-time is effective on the first day of the month following the date of the status change, provided any eligibility waiting period has expired. The eligibility waiting period begins on the employee's first day they move from part-time to full-time status.
  - If an employee is reinstated to a full-time status role within three months of moving to part-time, being laid off, and/or being terminated, they can obtain coverage on the Plan the first day of the month following the date of the status change. If an employee is reinstated to a full-time status role after three months of moving to part-time, being laid off, and/or being terminated, they are subject to the new-hire eligibility waiting period guidelines.

Policies/Procedures for Groups Applying for Coverage

Employer Contribution

On a monthly basis, the employer must contribute a minimum of 50% of the employee premium. It must be fair, equitable, and non-discriminatory toward any employee class.

Principal Ownership Companies

Principal ownership companies are eligible, given the following stipulations:

- There must be a consistent principal owner in all companies (i.e. the same individual holds the largest stake in each company. A 50% stake in a 50/50 ownership is acceptable).
- Multiple-partner companies must provide documentation of partnership arrangements—as well as written documentation—signed by all partners, outlining parties eligible to authorize changes to the group's employee benefit package and broker arrangements.
- There must be a clear and demonstrable relationship to each of the sub-companies.
- All of the employees will be used to determine rating and plan selection.
- Each company must maintain the same eligibility requirements, employer contribution and benefit plan.
- At any time, the group requests to divide the companies into separate group plans, the group will be re-underwritten using current quarter rates. Each company will be separately evaluated to determine an appropriate rating level and given a new contract period. Additional documentation may be

requested, such as waivers and/or applications or health questionnaires, from any employee not currently enrolled in the group's plan.

Group Waiting Periods

For current groups, the employees must meet the new hire waiting period established by the employer. At the employer's request, Sentara (the TPA) will waive the new hire waiting period for the initial enrollment of new groups but only if they do so for all employees. After initial enrollment, **the new hire waiting period can only be changed at renewal.**

Groups may elect to have different new hire waiting periods. Optima Health requires a waiting period no longer than first of the month following 60 days. For current groups, the employees must meet the new hire waiting period established by the employer. At the employer's request, Sentara Health Plan (the TPA) will waive the new hire waiting period for the initial enrollment of new groups but only if they do so for all employees. After initial enrollment, **the new hire waiting period can only be changed at renewal.**

Participation Requirements

Groups are required to have 70% participation of eligible employees and no less than 5 enrolling employees. Employees who waive coverage to stay on another qualifying plan (such as Medicare, TRICARE/CHAMPUS, or a spouse's employer-sponsored plan) are not considered eligible employees for the purpose of the participation calculation, and will not count against the group's participation. To determine group participation:

ABC Company	40	Total eligible employees (all full-time employees working 25+ hours weekly)
	-10	Employees enrolled on their spouses' or other plan (must have waiver)
=	30	Eligible employees to be counted toward participation requirement

Participation of 70% would require that 21 of the 30 potential enrolling employees participate in the Plan. Participation is a continuing requirement. Participation requirements must be met at the time the group is underwritten, and throughout enrollment under the Plan(s). Failure to maintain required participation levels may result in termination of the group at any time the participation falls below the required level. Renewal of a group may be contingent upon re-verification of group's employee participation.

There must not be more than 20% of the employees enrolling for coverage on COBRA/continuation at the time of enrollment.

The Employer Group Application must be submitted in order to show that the employer has authorized the submission of an application for group health insurance. A legal representative of the employer with signature authority must sign the application.

Employee Enrollment Application

New groups may either submit individual applications or use the Optima Health spreadsheet enrollment tool. If using applications, they must be completed and signed by the employee and BA. When requesting coverage for dependents, their enrollment must also be provided. **NOTE:** All sections of the application must be completed prior to submission. Incomplete applications may be returned to the employee for completion and may delay the enrollment process.

Each employee in a current group applying for coverage must complete an Employee Enrollment Application. The Application must be completed and signed by the employee and Plan Administrator.

Business*EDGE*® (5–250 enrolling employees) Enrollment Guidelines

When requesting coverage for dependents, their enrollment information must also be provided. **NOTE:** All sections of the Application must be completed prior to submission. Incomplete applications may be returned to the employee for completion and may delay the enrollment process.

OHP and OHIC will not accept any Employee Enrollment Application that is signed and dated by the applicant more than 90 days prior to the effective date of coverage. **Any Application signed more than 90 days prior to the effective date will require a new application.**

IMPORTANT: Agents/brokers and/or group representatives should NEVER complete an application for an applicant. In the event it is determined that an application has been completed and signed by someone other than the applicant, or a court-appointed representative for the applicant (documentation will be required), the information provided will be considered fraudulent and the group will be ineligible for coverage.

Waivers

Eligible employees who do not want coverage for themselves and/or any of their dependents are required to complete and sign the waiver section of the Application. Employees have the option of the following waiver selections:

- self, which will include all dependents
- spouse only
- child or children only
- spouse and child or children
- reason for waiver.
    - carrier and policy of other insurance if reason for waiver is other insurance (Optima Health reserves the right to verify other insurance coverage).

Employee and dependents who waive coverage will not be eligible to re-apply until the group's next Open Enrollment period, except in the case of a qualifying event.

Virginia Employment Commission Quarterly Wage and Earnings Report

Along with the completed Employer Group Application and Individual Employee Application, groups applying for coverage must also supply a copy of the group's most recent Virginia Employment Commission (VEC) Quarterly Wage and Earnings Report.

The VEC report must clearly indicate the current status of each employee on the report as either:

- full time (FT),
- part time (PT),
- not eligible (NE)—Please note class of ineligibility—i.e., part time less than 25 hours, in new-hire waiting period, active duty,
- terminated (T) (must provide date of termination), or
- waiving coverage (W) (waiver section of Application must be completed).

Changes/deletions made on the actual VEC report should be signed and dated by an authorized representative of the group.

If the company does not file a VEC (corporation, partnership, sole-proprietorship companies, church or non-profit organizations), the following information may be required:

- declaration letter listing all current eligible employees and social security numbers
- copy of business license
- papers of incorporation, listing principals/officers of the company
- partnership agreement
- W2 form (if applying for coverage at year end and prior to next quarterly VEC reporting, and/or employee is not considered a principal/owner of the company)
- 1040 Schedule C or F
- IRS Schedule K1 (Form 1065 or 11205)
- IRS Form 1120
- payroll summary

Additional VEC reports, or any of the documentation mentioned above, may be requested at any time after enrollment to verify the group's continued compliance with participation requirements.

Misstatement of Age or Class

If the age or level/tier of coverage of any insured employee has been misstated, the member's correct age or level/tier of coverage shall determine the amount payable under the Plan Document. All premiums due as a result of such misstatement will be adjusted and reflected on the group bill. Documentation may be required to validate corrections to previously stated information.

Rates presented on proposals reflect current census data. Birthdays occurring prior to the effective date may cause a change in premium.

Premium Check/Payments

The initial employer enrollment check, for the first month's premium (made payable to OHP or OHIC) will need to be submitted prior to enrollment. All deposits and premium payments must be from the group in the form of a company check, money order, or cashier's check. If an initial binder payment is returned for non-sufficient funds (NSF) or any other reason, coverage may be terminated as of the original effective date.

OHP and OHIC will not accept personal checks from the agent or broker in lieu of a check from the employer group.

Work-Related Illness and/or Injury

Employers are required to maintain a Workers' Compensation policy. Work-related illness/injury claims incurred by employees of an employer group will not be covered under their group health plan. This will apply to all employees, owners, directors, and/or officers of the company. Optima Health may require that the group provide the Workers' Compensation carrier name and policy number.

Stop-Loss Insurance

The employer's claims liability is limited in two ways:

- Specific stop-loss protects employers if any member's eligible claims exceed a specific amount/deductible. The specified deductible is based on group size. The stop-loss insurance will pay for all eligible claims exceeding the specified deductible for the remainder of the contract year.

- Aggregate stop-loss provides additional protection if the total eligible claims, after excluding individual claim amounts above the specific stop-loss level, for all members exceed a defined amount/ aggregate attachment point. If the eligible claims are higher than this amount, then the stop-loss insurance will pay for all eligible claims exceeding this amount for the remainder of the contract year.

Stop-Loss Advancements

If claims are unusually high early in the contract year and exceed the current claims fund balance, funds will be forwarded to the group to cover those costs; that money is recouped from future payments from the employer. The stop-loss insurance will be the group's safety net if claims continue at an elevated level. Advanced funds can be used for either specific or aggregate claims throughout the contract year, provided monthly payments are paid in full to date. If the group terminates the contract early, they are responsible for repaying the advancements.

Run-out Period

The run-out period is the time immediately following the end of the stop-loss insurance contract period during which Sentara Health Plan will accept and cover eligible claims that were incurred during the contract period.

The run-out period for the Business***EDGE*** contract will be 12 months after the end of the contract period. After the 12-month run-out period, if the group is still insured with Optima Health and actual claims history is lower than predicted, the group can collect a refund. The refund percentage of the unused claims fund is determined at the time the group is initially set up.

If the employer terminates the contract early, the stop loss policies are also terminated, and claims will no longer be processed. All payments made to Optima Health will be retained by Optima Health.

Guidelines/Policies/Procedures

Business*EDGE* New Business

Employer groups for Business***EDGE*** must have 5–250 enrolling employees.

All enrollment forms should be completed and received by Optima Health 10 days prior to their requested effective date of coverage.

Please allow no less than five business days for the completion of enrollment. Return of incomplete applications to the group/employee may also cause delays in the enrollment process. Please ensure all areas on the application are complete prior to submission to avoid unnecessary delays.

A group should not cancel their current coverage until a letter of notification is received from Optima Health. Group coverage is not in effect until written notification is received from Optima Health.

Initial Risk Assessment

The Employee Enrollment Application, which captures information regarding medical conditions and treatment of eligible persons, is made part of the application for insurance and shall be relied upon in determining rates and eligibility for coverage.

Business*EDGE*® (5–250 enrolling employees) Enrollment Guidelines

Optima Health has the right to revise the rates (retrospectively or prospectively) for the Stop-Loss Insurance Contract, or rescind or terminate the Stop-Loss Insurance Contract if a person completes the Employee Statement, Employee Application, Employee Enrollment Form, or other similar form (collectively "Form") with false, incomplete, or misleading information; or fails to notify Optima Health of any changes to the answers to the medical information question in any Form resulting in a material misrepresentation affecting the assessment of the risk or the terms or conditions for coverage.

Optima Health may follow-up with a phone interview regarding any missing or unanswered questions. Any health records from physicians/hospitals may also be requested and used for risk assessment purposes.

Those individuals who waive coverage and are covered under another company's COBRA plan will also be included in the risk assessment process. Any anticipated claims on these individuals will be assessed and could contribute to the group's rate-up in premium.

Installation of Group

With the completion of the risk assessment, if an offer is made for the stop-loss coverage, an offer notice will be sent to the broker that includes the final rates.

Enrollment Process

Business***EDGE*** groups may have an open enrollment period up until the fifteenth of the month prior to the group's effective date. Any employee who does not submit an application to Optima Health by that date will need to wait until the group's next open enrollment period to apply for coverage, unless there is a qualifying event. Any employee who does submit an application prior to the fifteenth of the month prior to the group's effective date (that will change the quoted census) may subject the group to underwriting review and re-underwriting. If a group wants to complete its open enrollment prior to the fifteenth and submit all enrollment material, Optima Health will accept the enrollment and the same guidelines (mentioned above with regards to qualifying event or not) apply to applications that come in after the enrollment submission date.

Please allow no less than five business days for the completion of enrollment. Return of incomplete applications to the group/employee may also cause delays in the enrollment process. Please ensure all areas on the application are complete prior to submission to avoid unnecessary delays.

A group should not cancel their current coverage until a letter of notification is received from Optima Health. Group coverage is not in effect until written notification is received from Optima Health.

Items required to complete the enrollment process include:

- The most current version of the Group Application for Employer Stop-Loss Insurance
- Complete Employee Applications for every employee who is applying for coverage or Enrollment Spreadsheet with all enrolling employees. All employees who are in their waiting period and are eligible for coverage within 90 days of the group's effective date should also complete an Employee Application. Applications must be signed and dated by applicant and plan administrator. **NOTE:** Any applications signed more than 90 days prior to the effective date will require a new, updated application. Any application submitted after the offer has been accepted could require the group to be re-underwritten, causing the group to be charged the appropriate premium as of the original effective date of the group.
- A complete group census form

- Waivers for eligible employees who are not electing coverage
- Prior carrier bill
- VEC, declaration letter, or other required eligibility documentation
- Binder Check (or Binder Check ACH)
- ACH (w/ voided check)

Failure to Disclose

Any information obtained regarding the group's compliance (or non-compliance) with new or renewing group caveats will be investigated as necessary. Non-compliance with said caveats, whether intentional or unintentional, will result in the termination of coverage if, in the sole judgment of Sentara Health Plans, Inc., the non-compliance is material to the group's eligibility or insurability. Groups are required to comply with requests for information relevant to the investigation within timelines provided. Failure to provide information may also result in termination of coverage.

Prior OHP or OHIC Group Coverage

Groups requesting coverage that have terminated prior OHP or OHIC coverage, voluntarily or involuntarily, will be subject to all new business enrollment and eligibility requirements.

Note: In the event group termination was due to non-payment of premium, group eligibility will be based on all new business requirements, and subject to reinstatement guidelines as outlined in this guide.

Termination of Coverage

If coverage is terminated prior to contract end date, the stop loss policies are also terminated, and claims will no longer be processed. All payments made to Optima Health will be retained by Optima Health.

Sentara Health Plans, Inc. may terminate coverage for:

- nonpayment of premiums
- fraud or intentional misrepresentation of material fact under the terms of the coverage

Additional Requirements/Information

Multiple plan offerings provide more flexibility for employers. They can request up to three different plan choices to meet their business and financial needs.

If an existing group splits for any reason, (for example, a change in ownership or sale of division), then all formed companies of the group will be issued a new contract period using the current quarter's rates. Additional documentation may be requested, such as waivers and/or Applications, from any employee not currently enrolled in the group's plan.

Acceptance

After Optima Health has received the group's acceptance, the following documents will need to be provided to the employer:

- Employer Contract
- Employee Applications or Enrollment Spreadsheet

- Waivers
- VEC
- Binder Check (or Binder Check ACH form)
- ACH (w/ voided check)

These documents need to be signed and dated by the employer and returned to Optima Health prior to the coverage effective date.

Membership Changes

Membership changes can be made effective the first of any month throughout the contract year (not retrospectively). Any changes will be subject to the following guidelines:

- All changes must be submitted within 60 days of new-hire eligibility or a HIPAA Special Enrollment Provision (qualifying life event).
- Requests to add a new employee or to add a spouse and/or dependent(s), to an existing employee's coverage must be submitted on an Optima Health Employee Enrollment Application. Applications must be complete and accurate. Applications to add newborns or adopted children must be received within 30 days from the date of birth or placement. Documentation must be provided to show the date of birth or adoption.
- The Employee Enrollment Application must be signed by the applicant and submitted within 31 days of the requested effective date.

Retroactive Disenrollment

Other than for a Rescission of Coverage for fraud, Optima Health can only terminate a member's coverage retroactively to a date in the past under specific circumstances.

The Group's coverage may be terminated retroactively due to failure to timely pay required premiums, in accordance with the Plan's 31-day grace period for premium payment.

For Plans that cover active employees, and if applicable dependents covered under state or Federal continuation of coverage provisions, coverage may be terminated retroactively due to a delay in the group's administrative record keeping if the employee or member did not pay any premium or contribution for coverage past the termination date or the date eligibility was lost. However, Optima Health will not retroactively cancel coverage during any period where the employee or member has incurred claims, unless premium has not been paid.

Coverage cannot be terminated retroactively if the employee or member was allowed to continue coverage and incurred claims after termination of employment or eligibility, and the employee or member paid premium or contributed to the cost of coverage after termination of employment or eligibility. In these cases, Optima Health can only terminate the member's coverage with a future date of termination. Coverage will usually end on the date through which premiums were paid.

If a group submits a retroactive-termination request to Optima Health, the employer must ensure that employees and dependents did not pay premiums/contributions during the retroactive-termination time period. When retroactive terminations are submitted, Optima Health will regard the submission as verification that no premium/contribution was paid by the member/dependent for that period.

The group shall notify Optima Health of any member who has become ineligible for continued coverage under the Plan for any reason. Notification must be made in writing and include the date of ineligibility. Notification must be received by the last day of the month in order to be incorporated into the next monthly billing cycle. Upon such notification, the Plan may refund to the group up to two months of premium payments made by the group on behalf of the ineligible member.

For Example: If notification is received no later than January 31 for a requested termination date of November 30, and the member has made no premium contribution, and no claims have been incurred, Optima Health will authorize a retro-termination date of November 30, and a credit for billed and paid premiums should occur on the group's next billing cycle.

If notification is received in February for a requested termination date of November 30 and the member has made no premium contribution, and no claims have been incurred, Optima Health will authorize a retro-termination date of December 31, and a credit for billed premiums should occur on the group's next billing cycle.

The group will maintain adequate records and provide any information required by Optima Health to verify that all Affordable Care Act (ACA) and all state Health Reform conditions for retroactive termination of coverage have been met. The Plan may examine the group's records relating to the coverage under this agreement during normal business hours at a location mutually agreeable to the group and the Plan. ACA means the Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and as it may be further amended.

Group Plan Changes

Changes in plan design or effective date can be made during the initial risk assessment process. However, once an offer has been accepted by the group and is returned to Optima Health, no changes can be made before the group's anniversary date.

Items that can only be changed at a plan's anniversary date are the Specific Deductible and Run-Out Period.

Any group requesting the addition of a subsidiary, location, a newly purchased company, or a new class of employees to its plans, or if a group composition changes by more than 10%, then the health plan for the entire group may be re-underwritten. The group could be assigned a new group number and also begin a new rate guarantee period. All claims history and accumulated benefits will be transferred to the new group health plan if appropriate. The premium rates will be the group's last renewal premium plus adjustments to reflect any demographic changes to the group, any noted medical/risk factors as a result of the additional new employees will also be factored in. The group must submit all the following:

- newly completed Group Application for Stop-Loss
- newly completed member application for any and all employees being added to the plan
- most recent State Quarterly Wage and Tax Statement (this may be required at the discretion of the underwriter)
- group employee census

Monthly Payment Amounts

The monthly bill will include costs for stop-loss insurance for the group, claim funding, and administrative expenses.

The premium for stop-loss insurance is the cost for this insurance protection, which covers any expenses that exceed the aggregate attachment point and specific deductibles.

The claim funding is used for the group's annual claim liability. The money belongs to the employer's health plan. Any money remaining at the time the surplus is determined will be refunded to the employer group, unless the contract is terminated before the end of the plan year.

The administrative expenses cover such costs as processing claims, available customer service, and network access and other administrative services.

The bill due date is noted on the bill. All payments must be received by the first of the month or coverage will be terminated. Optima Health will set up a monthly bank draw from the group to collect the monthly payment.

Rate Guarantee

All Business***EDGE*** groups will be given a 12-month rate guarantee and will be composite rated. Adjustments for age will only occur on the Plan's anniversary date.

Optima Health can change the monthly payment amount on any due date after it has been in effect for the active rate guarantee period. The rate guarantee periods do not apply to any adjustments due to the following:

- changes or more than 15% in the composition for covered employees
- any addition of a subsidiary, locality, a new startup company, or a new group class of employees coming onto its plan
- the business is no longer in the same type of business/trade as when the plan was originally effective
- any changes made to the plan's benefits
- any changes in the federal or state laws which could affect any covered employees. Optima Health has the right to make changes to the rates on any due date following the group's effective date of any state premium tax law or change to such law. This change and amount will be determined by the amount imposed by the new tax law.

Surplus Refund

Any group surplus will be determined in the thirteenth month after the end of the contract year. The group will be eligible to receive the surplus refund only if the group is still insured by any Optima Health group plan at the time of the surplus determination.

Renewal Proposals

The group will receive a written notice at least 30 days prior to their effective date of any rate change.

Prior to the end of the policy period, each employer could be required to submit a recent State Quarterly Wage and Earnings Report, as well as complete a form verifying the number of eligible employees and the number of participating employees in the group plan.

Groups will need to meet the required participation level. Optima Health can terminate any employer's plan for lack of participation on any payment due date with a 30-day advance notice.

Annual Open Enrollment Period

Business*EDGE*® (5–250 enrolling employees) Enrollment Guidelines

A Plan Open Enrollment Period shall be held annually. During the Plan Open Enrollment Period, each employee may apply for coverage as a subscriber for himself or herself and for eligible dependents. The employee must complete an Enrollment Application provided by the Plan. The Enrollment Application must include all eligible dependents, be signed, and completely filled out including all required information on the form.

Continuation of Coverage during Absence from Employment

A subscriber who is no longer an active employee may continue coverage for a set period of time, based on the circumstance.

- Approved leave of absence: a period not longer than 90 days
- Total disability: a period not longer than 180 days

Consolidated Omnibus Budget Reconciliation Act of 1985

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a Federal law, which states that employers of 20 or more employees maintaining a healthcare coverage plan must provide for the temporary continuation of coverage to employees or beneficiaries in certain instances where coverage would otherwise end. All employers are required to administer COBRA except the following:

- Employers with fewer than 20 employees
- Federal Government and the District of Columbia
- Church plans

OHP/OHIC agree to provide continued healthcare services, which will enable the group to comply with the requirements of COBRA, including the changes made under HIPAA, but disclaims any responsibility, implied or expressed, for such compliance.

Once a member becomes ineligible for coverage under the group plan, his/her coverage should be terminated effective the end of the month in which eligibility ceased. In addition, written notification must be received by the Plan when the member becomes ineligible.

Members electing COBRA must adhere to the following guidelines to receive continuation of coverage:

- Participants must provide notification of the COBRA election to the group within 60 days of the qualifying event.
- Payment of the first premium must be received by the group within 45 days from the date of the COBRA election. Subsequent payments should be received within 31 days of the due date.
- COBRA participants must remain current with premium payments. In the event the member does not make premium payment to the group within 31 days of the date due, the member's coverage should be terminated and the Plan notified.

NOTE: Non-payment of premium by the member to the employer group does not negate the employer group's obligation to pay the Plan for health insurance coverage provided by the Plan on the member's behalf.

When the group receives notification of the COBRA election:

- A new enrollment application must be completed or a copy of COBRA acceptance notice submitted.

- The completed application should be forwarded to the Plan within 60 days of the qualifying event for processing. Prior to forwarding the completed application to the Plan, please ensure that the COBRA election box is checked and the correct COBRA effective date is indicated.
- The employer is responsible for collecting premium payments from the COBRA member. In the event the member does not make a premium payment to the group within 31 days of the due date he/she should be canceled and the cancellation should be noted on the Group Statement and submitted to the Plan.
- The employer must determine and monitor the length of time a member may be eligible for COBRA coverage.
- When COBRA coverage exhausts or the member elects to terminate coverage, he/she should be canceled and the cancellation should be noted on the Group Statement and submitted to the Plan.

The Plan emphasizes that this is an employer law. This information is provided in an attempt to help with compliance only. If additional advice or information is needed, contact your company's legal office or attorney, or you may call the United States Department of Labor Pensions and Welfare Benefit Administration at 202-219-8776 or toll-free at 1-866-275-7922.

It is the Plan's responsibility to:

- Process completed COBRA applications upon receipt, and
- Bill the employer for all COBRA participants under a COBRA subgroup.

Twelve-Month Continuation of Coverage

Groups not eligible for COBRA have a Continuation of Coverage for employees who lose eligibility under the group plan. Employers and members can refer to their coverage documents for complete details and requirements.

Continuation of Coverage under the group policy is allowed for a period of no more than 12 months immediately following the termination date of the person's eligibility, without evidence of insurability.

The application for the extended coverage is made to the group policyholder within 31 days after issuance of the written notice, but not to exceed the 60-day period following the termination of the member's eligibility. The premium for continuing the group coverage shall be at the insurer's current rate applicable to the group policy. Continuation shall only be available to an employee or member who has been continuously insured under the group policy during the entire three-month period immediately preceding termination of eligibility.

The employer is required to provide each employee written notice of the availability of the option chosen and the procedures and timeframes for obtaining continuation of the group policy. Notice shall be provided within 14 days of the employer's knowledge of the employee's loss of eligibility under the group policy.

Individual & Family Health Plans

Employees and dependents no longer eligible for coverage through an employer group qualify for a Special Enrollment Period and may apply for an Individual & Family plan. Inquiries, applications, or additional information may be obtained by contacting Optima Health directly at optimahealth.com/individual, or the Health Insurance Marketplace at HealthCare.gov.

Business*EDGE*® (5–250 enrolling employees) Enrollment Guidelines

Medical Loss Ratio Rebate Distribution

Under the ACA, Optima Health is required to provide an annual rebate to enrollees if the insurer's medical loss ratio (MLR) fails to meet minimum requirements. If the Optima Health MLR fails to meet the minimum requirements set by ACA, Optima Health shall provide any such MLR rebate directly to the group policy holder. The Optima Health MLR will be calculated at the book-of-business level within the Virginia State regulatory classification definitions of Small Group (1–50 employees) and Large Group (51+ employees) for each of our legal entities (OHP and OHIC). The group is solely responsible for distribution of any MLR rebate to the applicable group plan enrollees subject to the following conditions:

- Optima Health shall remain liable for complying with all of its obligations under ACA concerning MLR rebates.
- The Group shall maintain and provide upon request to Optima Health any and all records and documentation evidencing accurate distribution of any rebate owed, sufficient to demonstrate compliance with the ACA, including but not limited to the following:
  - amount of the premium paid by each subscriber under the group plan
  - amount of the premium paid by the group
  - amount of the rebate provided to each subscriber
  - amount of the rebate retained by the group
  - amount of any unclaimed rebate, and how and when it was distributed

Understanding the Group Billing

A group bill consists of four parts, if applicable:

- **The Group Statement**: A summary of all charges and/or credits, listing the unpaid balance from prior periods, total premiums for active subscribers in the current month, total retroactive adjustments, and the total amount due. The group number, group name, address, and contact person will be in the upper left corner. The statement number, statement date (bill generation date), due date, and period covered will be in the upper right corner.
- **The Subscriber Reconciliation List**: This section details all active subscribers for the current month. Subscriber numbers, identity numbers, contract types, and subscriber premiums are listed. The subscriber premium total ties to the premium for active subscribers on the Group Statement.
- **The Retroactive Adjustment**: Any prior period billing adjustments are shown on this report. The total of the report ties to the retroactive adjustments on the Group Statement.
- **The Group Reconciliation Statement**: A form to forward monthly additions and termination back to the Plan.

Other important billing information:

- Ninety-tier rate structure for all new small groups and any existing small groups as they renew.
- The layout of the group billing statement has changed to portrait, previously landscape, once changed to 90-tier.
- **Group billing**: Group billing is calculated on a full month proration basis. The group will be billed a full month's premium for any member whose coverage is effective for any portion of the month.

Business*EDGE*® (5–250 enrolling employees) Enrollment Guidelines

- **Renewal Bills**: Each year, at the employer group's anniversary period, the monthly billing will be slightly delayed until the anniversary period ends. This is to allow adequate time for re-enrolling the group and subscribers.
- **Grace period:** The Plan allows a 31-day grace period for the payment of premiums. Failure to pay premiums within the grace period may result in termination of your group's coverage.
- **Payments returned for non-sufficient funds:** Group coverage may also be terminated if a premium payment is returned for non-sufficient funds. If a group is reinstated following a non-sufficient fund termination, future premiums must be paid with certified funds. A $25 service charge will also be applied for payments returned for this reason.
- **Reinstatement**: The Plan will allow for reinstatement of a group health plan with payment of all past due and current premiums within 15 days of the date of termination. Groups that have been terminated for non-payment three times in a 24-month period are ineligible for reinstatement

Employee Contacts at a Glance

The following information will help you direct your employees to the right Optima Health resources.

Online and Mobile

Visit optimahealth.com or the Optima Health mobile app to:

- Access MDLIVE® virtual visits
- View a list of Plan providers
- Change your Plan primary care physician (PCP)
- Update your home address, phone number, or email address
- View and order a member ID card
- View your claims history
- View your benefits
- View your authorizations
- View deductible and maximum out-of-pocket accumulators
- Download member forms
- Learn about member discounts
- Manage your pharmacy benefit (if administered by Optima Health)
- Research drug options and pricing
- Choose to receive your Explanation of Benefits (EOB) electronically
- Research conditions, treatment options, and hospital quality
- Find costs for over 500 treatments and services
- Contact Member Services

You will need to register on optimahealth.com or the mobile app to access your secure member information as well as special tools available only to Optima Health members. The Optima app can be downloaded from the App Store or Google Play.

Email members@optimahealth.com

Please note: *To protect your privacy, we may not be able to provide all information via email. Members who register and sign in to optimahealth.com can contact Member Services securely using the Contact Us form. For the most up-to-date customer service numbers, please refer to the numbers located on the back of your Member ID card.*

Mail

Optima Health Member Services
4417 Corporation Lane
Virginia Beach, VA 23462

Member Services

1-877-552-7401 or 757-552-7401
Office hours: Mon.–Fri., 8:00 a.m. to 6:00 p.m.
After normal business hours, please leave a message.

After Hours Nurse Advice Line

The After Hours Nurse Advice Line can be reached 24 hours a day at 1-800-394-2237 or 757-552-7250. This does not replace contacting your doctor during regular office hours. The After Hours Nurse Advice Line can answer injury or illness questions when your doctor's office is closed.

TDD/TYY lines for the hearing-impaired

711 or 1-800-828-1140

Language services for non-English speaking members

Call 1-855-687-6260 to access language services

Behavioral Health Services

1-800-648-8420 or 757-552-7174

Employee Frequently Asked Questions (FAQs)

How do I register on optimahealth.com and the mobile app?

A covered member on the health plan, aged 18 or older, can go to the registration page on optimahealth.com. A member ID card is needed when registering.

What do I do if I forget my password or username?

If you forget your username, you will need to go through the registration process again.
If you forget the password, go to "Change Password" to reset it. The secret answer to a secret question chosen in the registration process will allow you to reset the password. The answer to the secret question is case sensitive. If you do not remember the secret question and answer, you will need to re-register or contact Member Services at the number on the back of your member ID card to have your password reset.

What do I do if I have questions about the information I see on optimahealth.com or the mobile app?

Contact Member Services at the number on the back of your member ID card or online through our "Contact Us" form.

How do I know my information is safe/secure?

We are required by law to:

- Ensure medical and/or personal information is kept confidential;
- Make available a notice of our legal duties and privacy practices; and
- Follow the terms of the notice that are currently in effect.

Links to our policies and disclosures are available at the bottom of most pages on optimahealth.com.

How do I allow my spouse to view my claims?

Simply register and sign in to optimahealth.com. Once you are signed in, you will notice a check box option on "View Medical Claims" and "View Referrals/Authorizations." If you elect to allow your covered spouse to view your information, he or she will see that option the next time he or she signs in. You can grant or remove spouse access at any time.

Can I view my college-age dependent's claims?

No. Members age 18 and over may register to view their claims and other health plan information. Members can view or perform certain self-service functions for covered dependents under the age of 18. These self-service functions include view claims, view referrals/authorizations, change contact info, change PCP and view summary of benefits.

How can I access my child's pharmacy claims?

Currently members are only able to access their specific pharmacy claim information. We are working to allow members to view covered dependents in the future.

How do I know if my prescription drug is covered?

You can search our drug lists using the Drug Search Tool. Covered Members may also sign in to determine coverage and exact Copayment amount using the "Pharmacy Resources" link located on the left-hand menu.

Where do I find benefit information?

Sign in to view your Benefit Summary and Uniform Summary of Benefits and Coverage documents.

Optima Health
4417 Corporation Lane
Virginia Beach, VA 23462
757-687-6030
1-877-552-7401 (Toll-free Hampton Roads)
1-866-575-4475 (Toll-free Virginia Statewide)

www.optimahealth.com