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# 2022 Benefits Administrator OFFICE GUIDE

Large Group
151+ Eligible Employees

OptimaHealth

# BENEFITS ADMINISTRATOR OFFICE GUIDE

## LARGE GROUP
## (151+ ELIGIBLE EMPLOYEES)

January 2022

v. 1021

# 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**
**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**

# Large Group (151+ eligible)
# Enrollment and Underwriting Guidelines

## Segment Determination for Fully Insured Groups

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 151 are eligible, the group is mid-market and underwritten.
    b. If 151 or more are eligible, the group is underwritten in large group.

## Employers, Employee, and Dependent Eligibility

### Eligible Employers

- Corporations or partnerships with a clear employer/employee relationship with 151 or more eligible employees.
    - To calculate eligible employees, include owners and partners but exclude COBRA participants (who are eligible for coverage but not counted to determine Large Group eligibility).

### Eligible Employees

An employee is eligible for coverage if he/she:

- is employed by the group
- is at least 17 years of age
- is working regularly at least 30 hours per week, 50 weeks per year
- within 31 days of the effective date of coverage files a complete enrollment application, including any applicable premium or fees, with the Plan
- does not knowingly give incorrect, incomplete, or deceptive information regarding his/her eligibility for coverage to the Plan or to the employer group
- does not knowingly give incorrect, incomplete, or deceptive information regarding his/her dependent's eligibility for coverage to the Plan or to the employer group
- meets any other requirements as specified by the Plan or by the employer group (such as early- and Medicare-eligible retirees or pensioned employee)

Retired employees may be eligible depending on the group's criteria and history. An additional premium may be associated with this eligible class.

Employers with variable-hour employees who qualify for health insurance outside of the open enrollment period must provide a statement or indicate on the application that the employee is a **variable employee who has met the necessary criteria to be enrolled.**

**Note:** For current groups, the employees must meet the new-hire waiting period established by the employer. New groups can waive the new-hire waiting period at the time of the Group's initial enrollment with OHP or OHIC, but only if they do so for all of the employees. After initial enrollment, the new-hire waiting period can only be changed at renewal.

## Out-of-Area Employees

Employees who reside 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 and will be offered an OOA PPO plan.

The networks used for the PPO and OOA PPO products, are the Optima Health PPO network and a contracted national PPO 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 the 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, or leased, temporary, or seasonal employees
- directors, board members, and officers not otherwise eligible as active, full-time employees

## Eligible Dependents

- legal spouse of the insured employee
- children up to the end of the month (EOM) or end of year (EOY) in which they turn age 26, depending on what is requested and underwritten. Eligible children include:
  - natural or stepchildren
  - foster children
  - legally adopted children
  - children placed with 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/EOY 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/EOY does not extend to a spouse of a child receiving dependent coverage. Eligibility to age 26 EOM/EOY 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/EOY 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.

Domestic partners may be eligible depending on the group's criteria and history. An additional premium may be associated with the addition of this eligible class.

## 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 PPO 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 PHCS/Multiplan national network of providers. Pre-Authorization applies as necessary. The dependent child(ren) residing outside of the area must provide validation annually. Each eligible child will receive a special ID card with a PHCS/Mulitiplan logo on the front of the card, indicating participation in the program.

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.

## Out-of-Area Dependent Children Rider

Additionally, employers with employees who request coverage for eligible dependent children who reside outside of the OHP or OHIC service area may elect to purchase the Out-of-Area Dependent Rider. This rider allows for dependent children living outside of the service area to receive services from **any provider** at in-network benefit levels. Providers outside of the service area may require payments from subscriber/dependent at the time services are rendered. Subscriber may then submit the claim to the Plan for reimbursement of charges, less applicable in-network Copayments or Coinsurance requirements.

The addition of this rider to a new or existing group will add a surcharge to the group's premiums for all plans purchased, not just for the plan chosen by the member(s) who currently enroll OOA children. The rider will remain as a benefit of the group, until Optima Health receives written notification from the group BA to request removal of the rider at the group's next renewal date.

Groups electing this rider must have employees with OOA dependent child(ren) complete an Out-of-Area Dependent Child Notification Form annually for each covered OOA dependent child.

**NOTE:** This rider will not be added to a group on a retroactive basis.

## Dependents NOT Eligible

- dependent children over age 26 EOM/EOY, unless incapable of self-support due to intellectual disability (dependent age limits may be modified to cover children older than 26 EOM/EOY upon group request and underwriting approval at initial enrollment or prior to annual renewal)

- 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

## Dependent Verification

OHP or OHIC may, at its discretion, 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

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 PHCS/Multiplan national providers.

The Plan 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 the Plan 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, the Plan may, at its sole discretion, either refund all or part of the premium payment made on behalf of the subscriber/dependent to the group and retract all or part of any claims paid from the provider(s), or retain the premium paid on behalf of the ineligible subscriber/dependent up until the date the Plan became aware of the ineligibility and cancel the subscriber's/dependent's coverage after the date through which premiums were paid. 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 for any charges for claims for services during the period of ineligibility.

## HIPAA Special Enrollment Provisions

The Plan will provide special late enrollment periods for eligible employees and dependents that fall into the following categories:

- **Late enrollees with other coverage.** Employees or dependents who initially decline coverage because they have other group health coverage or other health insurance, will be allowed to enroll late without evidence of insurability if the following three conditions are met:
  - The employee and/or dependent must be eligible under the Plan's terms;
  - When the employee declined enrollment for the employee and/or dependent, the employee stated in writing that the reason for declining enrollment was because they had other coverage, if the Plan requires such a statement and if the employee was notified of the requirement to provide a written statement at the time they declined coverage; and
  - When the employee declined enrollment for the employee and/or dependent, either the employee and/or dependent had COBRA continuation coverage under another plan and that coverage has since been exhausted; or if the other coverage was not under COBRA, either the other coverage has terminated as a result of loss of eligibility, or employer contributions toward the other coverage have terminated.

  **Effective Date of Enrollment.** Individuals must request enrollment no more than 31 days from the time that the individual knew or should have known that the other coverage has been exhausted. Late enrollment is effective no later than the first day of the calendar month beginning after the date a completed request for enrollment is received by the Plan.

- **Late enrollees due to marriage, birth, adoption, or placement for adoption or foster care.** If a dependent is added through marriage, birth, adoption, or placement for adoption or foster care, the employee and all dependents are entitled to become covered through special late enrollment. Individuals in this category do not have to have declined coverage because they had other coverage.

  **Effective Date of Enrollment.** Individuals must request coverage within 31 days of the marriage, birth, adoption, or placement for adoption. For special enrollment due to birth or adoption, late enrollment is effective on the date of the birth, adoption, or placement for adoption. For special enrollment due to marriage, late enrollment is effective no later than the first day of the calendar month beginning after the date a completed request for enrollment is received by the Plan.
- **Special enrollment for employees and/or dependents that lose eligibility under Medicaid or CHIP coverage.** Employees and/or dependents who are eligible for group coverage will be permitted to enroll late if they either lose eligibility for Medicaid or CHIP coverage, or become eligible to participate in a premium-assistance program under Medicaid or CHIP.

  **Effective Date of Enrollment.** Individuals must request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

## Policies/Procedures for Groups Applying for Coverage

### Employer Contribution to Premium

Optima Health requires an employer contribution of at least 50% of the single employee premium. On a dual or triple option basis, Optima Health requires a contribution of at least 50% of the lowest premium plan. If the employer does not meet this minimum contribution level, rates may be adjusted.

### Employer Contribution to Deductible

Proposed rates for all plans assume that employer contribution to any plan Deductible (through contributions to a Health Savings Account (HSA) or Health Reimbursement Account (HRA), or any other arrangement) will not exceed 50% of the single deductible and/or 50% of the family deductible. Optima Health reserves the right to adjust rates if Deductible funding for any plan is higher than this 50% assumption.

### 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).
- 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.
- In the event that the group wishes to divide the companies into separate group plans, each company will be separately evaluated to determine rating and plan coverage.

# Large Group (151+ eligible)
# Enrollment and Underwriting Guidelines

## "Class" Groups

Optima Health can administer different coverage for classes of employees. The determination of whether there is discrimination in benefits, premium contribution, and waiting periods will not be made by Optima

Health. Employers must consult with their legal and tax advisors on this matter. Employers that discriminate in their healthcare plans may be subject to financial and tax penalties.

## Participation Requirements

Groups are required to have 75% participation of eligible employees enrolled in a qualifying health plan. Employees who waive Optima Health coverage to stay on another qualifying plan (such as Medicare, TRICARE/CHAMPUS, or a spouse's employer-sponsored plan) are considered enrolled employees for the purpose of this calculation.

**Participation is a continuing requirement. Failure to maintain the applicable participation level after initial enrollment or anytime during the contract period may result in a rate adjustment.**

## Work-Related Illness and/or Injury

Work-related illnesses and/or injuries are not covered by OHP or OHIC group policies for groups with more than three employees.

## Group Acceptance

OHP and OHIC premium levels are developed in part based on the completeness and accuracy of the Employer Group Health Questionnaire.

Omission of information on the Employer Group Health Questionnaire or the Employee Application, whether intentional or unintentional, may result in a retroactive adjustment to premium. If the omitted information reveals that the group and/or individual is not eligible for coverage, then the group/individual will be terminated.

## Size and Underwriting Limits

Large Group is defined as employer groups with 151 or more eligible employees. The number of eligible employees determines if a group is a mid-market group vs. large group, not the number of employees actually enrolling.

If actual enrollment on the initial effective date varies from the census used to calculate rates by 15% or more, the group may be re-rated.

Companies originally written as large groups that decrease their employee base to fewer than 151 eligible employees during the contract year will remain large groups until renewal. At renewal, such groups will be reviewed on a case-by-case basis to determine their status as a large group vs. mid-market group. The same review will apply to small or mid-market groups that increase above 150 eligible employees during the contract year.

### Request for Proposals

The broker/consultant should allow a turnaround time of 5–10 business days for large group quotes (151+ eligible), once all data required is provided. For formal RFPs with multiple exhibits, a minimum lead time of four weeks is requested.

The following information is needed to receive a quote from Optima Health:

- complete and accurate employee census—showing date of birth, gender, tier, plan, and zip code (indicate Other Coverage or None for those who have not elected coverage)
- group's current and renewal rates
- 24 months of claims experience with corresponding employee and member enrollment by month. Provide report of large claimants for the same 24-month period. Explain any gaps in the experience. If group does not have claims experience, please state why. If no experience, please provide copies of the last two renewals and current (three total)
- benefit summaries for the experience period, noting any changes during the experience period and whether accumulators were calendar year or plan year
- completed Optima Health Employer Group Health Questionnaire signed by the employer or Benefit Administrator
- employer contribution amounts and/or percentages and waiting period for new hires
- top facilities and providers used during the experience period
- requested commission level

### Quote and Proposal Criteria

- Large group (151+ eligible) proposed rates will be determined by using a combination of community rating and experience rating, based on the credibility of the claims experience provided. Other characteristics of the group, including—but not limited to—participation, contribution, industry, and carrier persistence are also included in the rate development.
- Brokers/consultants should review and follow the most current Large Group Submission Checklist (can be obtained from any member of the Large Group sales team) to ensure a complete submission and to receive a timely response.

### Premium Check/Payments

Premium payments must be from the group in the form of a company check, electronic money transfer (EFT), money order, or cashier's check.

OHP and OHIC will not accept checks from the agency, agent, or broker; or any other third-party payment in lieu of a check from the employer group.

## Continuation of Coverage

### 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.

## 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 Statement

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:

- **Group billing**: Large group (151+) Group billing is calculated on full/half or daily proration, based on the group's selection at contract set-up.
- **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.
- **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.

# Employee Frequently Asked Questions (FAQs)

## How do I register my secure online account?

A covered member on the health plan, aged 18 or older, can go to the registration page on optimahealth.com or download and register on the Optima Health mobile app.

## 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 through our "Contact Us" form on optimahealth.com and the mobile app.

## 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 or the mobile app. 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 the Benefit Summary.

## 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.

# 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 virtual consults
- 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.

### 24/7 Nurse Advice Line

The 24/7 Nurse Advice Line can be reached at 1-800-394-2237 or 757-552-7250.
This does not replace contacting your doctor during regular office hours. The 24/7 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


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)

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