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Benefits Administrator

OFFICE GUIDE

Mid-Market Group
More than 50 Total Employees and
150 or Fewer Eligible Employees

OptimaHealth

BENEFITS ADMINISTRATOR OFFICE GUIDE

MID-MARKET GROUP (MORE THAN 50 TOTAL EMPLOYEES AND 150 OR FEWER ELIGIBLE EMPLOYEES)

January 2022

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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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Mid-Market Group (over 50 total employees, 150 or fewer) 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, partnerships, or sole proprietorships with a clear employer/employee relationship (1099 employee relationships are not eligible for group coverage)
- Employer groups not formed for the sole purpose of securing insurance
- Employer groups located within the Optima Health plan service area

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. In each of these cases, an employer participating in a contracted private exchange may be exempted.

Eligible Employees

An employee is eligible for coverage if he/she:

- is employed by the group
- resides or works in the service area or is an out-of-area employee
- is working regularly at least 25 hours per week
- is at least 17 years of age
- within 31 days of the date of initial eligibility, 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 herein, or as specified by the Plan or by the employer group
- retirees, as long as the employer contribution is the same as full-time employees

The employee must appear on the employer's most recent 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.

Self-employed proprietors, directors, or partners of a company are not excluded, provided they meet the criteria listed above. Any 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 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

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."**

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 and will be offered an OOA PPO plans. It is recommended that no more than 20% of the covered employees can be covered under the OOA PPO.

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 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

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; and
    - are jointly responsible for each other's welfare and financial obligations; and
    - reside in the same household; and

- 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; and
- 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; and
- 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 step children
  - 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 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 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.

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.

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 intellectual 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

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

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.

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:

- 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;
- 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; or
- 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. The Plan 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

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.** If a dependent is added through marriage, birth, adoption, or placement for adoption, 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.

Effective Date of Coverage

Subject to the Plan's receipt of an enrollment application 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.

- **Subscriber Coverage.**
  - When a person completes a written 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 a written 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.
- **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.
- **Newborn Children.** Newborns will be covered from the moment of birth for 31 days, if the subscriber's coverage under the Plan is in effect. In order for coverage to continue beyond 31 days, the subscriber must add the newborn to their coverage within 31 days of birth. An adopted child whose placement has occurred within 31 days of birth will be considered a newborn child of the subscriber, as of the date of adoptive or parental placement. The newborn child's coverage will be identical to coverage provided to the subscriber. If the newborn is not added to the Plan within 31 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 31 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 31 days from the date of placement. If the

adopted or foster child is not added to the Plan within 31 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 31 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 Benefits Administrator (BA), or the date the BA 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 60 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.** Employees whose employment status changes from part time to full time must meet the employer's eligibility waiting period before they can begin coverage.
  - 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 single 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 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.

"Class" Groups

The ACA applies the same non-discrimination requirements to fully insured group health plans that currently apply to self-funded group health plans. These requirements prohibit employers from establishing rules relating to eligibility for healthcare coverage that are based on an employee's total hourly or annual salary, and discriminating in favor of highly compensated individuals. Highly compensated individuals generally include the five highest-paid officers, any 10% owners, and the highest-paid 25% of all employees. This change will preclude employers from providing special health insurance coverage to their executives and other highly compensated employees on a pre-tax basis.

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.

Groups with 51–150 total employees may elect to class out a portion of their total group as long as they meet the non-discrimination requirements. They may have a total of no more than one singled-out class to receive coverage. Participation must be no less than 70% of the total eligible employees of the single class, but may not be any less than 10 total enrolled subscribers from the single class.

Waiting Periods/Contributions

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.**

Groups may elect to have different new-hire waiting periods and/or employer contributions for different classes. The effective date must be on the first of the month. Optima Health requires a waiting period no longer than first of the month following 60 days.

Probationary/Orientation Periods

A probationary/orientation period is permitted only if it does not exceed one month and is not designed to get around the 90-day waiting period limit. For this purpose, one month is determined by adding one calendar month and subtracting one calendar day, measured from an employee's start date.

> For example, if an employee's start date is May 3, the last permitted day of the orientation period is June 2. Similarly, if an employee's start date is October 1, the last permitted day of the orientation period is October 31. If there is not a corresponding date in the next calendar month upon adding a calendar month, the last permitted day of the orientation period is the last day of the next calendar month. For example, if the employee's start date is January 30, the last permitted day of the orientation period is February 28 (or February 29 in a leap year). Similarly, if the employee's start date is August 31, the last permitted day of the orientation period is September 30.

Mid-Market Group (over 50 total employees, 150 or fewer) Enrollment and Underwriting Guidelines

Participation Requirements

Groups with 51 or more total employees with less than 70% participation may be subject to a low participation load. 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	75	Total eligible employees (all full-time employees working 30+ hours weekly)
	-15	Employees enrolled on their spouses' or other plan (must have waiver)
=	60	Eligible employees to be counted toward participation requirement

Participation of 70% would require that 42 of the 60 potential enrolling employees participate in the Plan. Participation is continually reviewed.

Groups with valid waivers that leave only one enrolling employee will be allowed to enroll and/or renew their health coverage.

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.

Employer Group Health Questionnaire

Groups may apply for coverage by submitting an Optima Health Employer Group Health Questionnaire and a complete employee census to include the following information:

- name of employee (optional)
- date of birth of employee (required)
- gender of employee (required)
- Social Security number of employee and dependents (optional, required for enrollment)
- level or tier of coverage (required) as follows:

  - employee
  - employee + 1 child
  - employee + spouse
  - employee + children
  - family
  - waiver—other coverage
  - waiver—other

If a group accepts the final underwritten rates, the employees applying for coverage must complete an Optima Health Employee Application for the enrollment process. These pages must be completed and signed by the employee and the BA. When requesting coverage for dependents, their enrollment information must also be provided.

Mid-Market Group (over 50 total employees, 150 or fewer) Enrollment and Underwriting Guidelines

OHP and OHIC will not accept any Employer Group Health Questionnaire signed and dated more than 120 days prior to the effective date of coverage. **NOTE:** Any Application signed more than 90 days prior to the effective date will require a new application.

Employees who decline coverage for any reason, and later decide they want to apply for coverage, will only be eligible for coverage at open enrollment, or in the case of a qualifying event, on the first of the month after receipt of their completed Application/Health Questionnaire, provided they are determined eligible to add coverage at this time.

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/Health Questionnaire. 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).

Virginia Employment Commission Quarterly Wage and Earnings Report

Along with the completed Employer Group Application and Individual Employee Application/Health Questionnaires or Employer Group Health Questionnaire, groups applying for coverage must also supply (may be required prior to submission for underwriting) 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: part time less than 30 hours, in new-hire waiting period, active duty
- terminated (T) (must provide date of termination)
- waiving coverage (W) (waiver section of Application/Health Questionnaire must be completed)

A letter signed by an authorized representative of the group is required to verify eligibility for any newly hired employees or owners not listed on the VEC report. In addition, 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, gender, or level/tier of coverage of any insured employee has been misstated, the member's correct age, gender, or level/tier of coverage shall determine the amount payable under the group policy. 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. A misstatement in age may also cause the group to be re-rated.

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. Groups should not submit their initial premium check until after underwriting and final rate determination has been made. 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 checks from the agency, agent, or broker in lieu of a check from the employer group.

Work-Related Illness and/or Injury

Employers with three or more employees (full time and/or part time) are required to maintain a Workers' Compensation policy. Work-related illness/injury claims incurred by employees of an employer group of three or more employees 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.

Guidelines/Policies/Procedures

Mid-Market Group New Business

Mid-Market is considered to be employer groups with 51 or more total employees and 150 or fewer eligible employees. The eligible count includes employees waiving coverage. The number of eligible employees determines if a group is a mid-market group vs. large group, not the number of employees actually enrolling.

Mid-Market Group (over 50 total employees, 150 or fewer) Enrollment and Underwriting Guidelines

Please allow no less than five business days for the completion of underwriting. Occasionally additional information may be required for the purposes of underwriting, which may increase the turnaround time for final rate determination, such as a request for Attending Physician Statement(s). Return of incomplete applications to the group/employee may also cause delays in the underwriting process. Please ensure all areas on the application are complete prior to submission to avoid unnecessary delays.

Groups requesting a first-of-the-month effective date will need to submit all information necessary for enrollment prior to the close of business on the last date of the prior month.

Items required to complete the enrollment process include:

- Employer Group Application
    - Optima Health Employee Application
    - Waivers for eligible employees who are not electing coverage
- VEC, declaration letter, or other required eligibility documentation
- First month's premium

Risk Acceptance

OHP and OHIC approval of coverage for eligible employees or dependents is subject to the completeness and accuracy of the Employee Application/Health Questionnaire and/or the Employer Group Health Questionnaire, and the Employer Group Application.

Omission of information on the Employee Application/Health Questionnaire, the Employer Group Health Questionnaire, or the Employer Group Application, whether intentional or unintentional, will result in the termination of coverage if, in the sole judgment of OHP or OHIC, the omitted information was material to the person(s)' or group's eligibility or insurability.

Any information obtained regarding the group's 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 OHP or OHIC, 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.

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

OHP and OHIC may terminate coverage for:

- nonpayment of premiums
- fraud or intentional misrepresentation of material fact under the terms of the coverage
- violation of participation or contribution rules

New Employee Applications/Health Questionnaires submitted within 120 days of the group's initial effective date or renewal date may require the group to be resubmitted to underwriting for reevaluation and possible rate adjustment.

Mid-Market Group (over 50 total employees, 150 or fewer) Enrollment and Underwriting Guidelines

IMPORTANT: Agent/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 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.

Additional Underwriting Requirements/Information

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.

Groups requesting two plans must have a minimum of two enrolling employee subscribers. If a group under 15 would like to offer three plans they must have at least two enrolling employees and one of the plans must be an Equity Consumer-Directed Health Plan. Groups requesting four plan offerings must have a minimum of 15 enrolling employee subscribers. **Note:** HMO plans are not available in all service areas.

Rates presented on proposals reflect current census data. Birthdays occurring prior to the effective date may cause a change in premium. A misstatement in age may also cause the group to be re-rated.

Companies originally written as a mid-market group (51 or more total employees) that increase their employee base to 151 or more during the contract year will remain mid-market group until renewal. At renewal, such groups will be reviewed on a case-by-case basis to determine their status as a mid-market group vs. large group. The same review will apply to large groups that fall below 151 total employees during the contract year.

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 reevaluated using the current quarter's rates to establish the appropriate rating levels and given a new contract period. Additional documentation may be requested, such as waivers and/or Applications/Health Questionnaires, from any employee not currently enrolled in the group's plan.

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 Application/Health Questionnaire. Applications/Health Questionnaires must be complete and accurate. Applications to add newborns or adopted children must be received within 31 days from the date of birth or placement. Documentation must be provided to show the date of birth or adoption.
- The Application/Health Questionnaire must be signed by the applicant and submitted within 30 days of the requested effective date.
- Membership additions/changes that are submitted within 90 days of the group's initial effective or renewal date may require the group to be resubmitted to underwriting for re-evaluation and rate adjustment.
- In the event that enrollment changes increase or decrease the group's existing census by 15% or more, the group will be subject to underwriting review and may be re-rated for a new contract period using the most current rates available.

Retroactive Disenrollment

Other than for a Rescission of Coverage for fraud, Optima Health can only terminate a member's coverage 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.

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 group 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 the Plan 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 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 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.

Plan Changes

Plan changes should be done at the time of renewal. However, Optima Health will allow one off-cycle plan change per year during the contract year, subject to the following timeline:

- Requests for proposal for off-cycle changes must be received by Optima Health, in writing from the company or the agent/broker, at least 75 days prior to the requested effective date.

- A final decision on any potential change–including exact plan designs to be offered and any required supporting documentation—must be received by Optima Health at least 65 days in advance of the proposed effective date. Please note that if day 65 falls on a weekend or holiday, Optima Health will need the decision by the last business day beforehand.
- Upon receipt of the final decision, the Optima Health Account Executive will forward via email the appropriate new Summary of Benefits and Coverage (SBC) document(s), for distribution by the group to its employees 60 days prior to the change effective date.
- Please allow no less than five business days for the completion of plan change requests.
- Any group making an off-cycle change will receive a new contract year/effective date using current quarter rates. All member deductible and maximum out-of-pocket accumulators will reset with the new effective date.
- If groups do not meet these timelines, they will have to wait until the following month to make their benefit change.

REMINDER: Effective dates for benefit changes requested off anniversary date will be determined by Optima Health. Under no circumstances will Optima Health allow retroactive plan changes.

Premium Payments

Premium payments are due on the first of each month. A group's failure to pay premiums within the 31-day grace period will result in termination of the group health plan.

Reinstatement of Groups Terminated for Non-Payment of Premium

Groups canceled for non-payment may be eligible for reinstatement under the following guidelines:

- Payment of past-due premium is received by Optima Health no later than close of business on the first of the month following the date of cancellation.
- Payment of past-due and current month's premium payment is received by Optima Health between the second and fifteenth day of the month following the date of cancellation.

Note: Groups and members will NOT be reinstated in the system until payments are received and posted according to the above guidelines.

Groups submitting premium payments after the above referenced timelines will be ineligible for reinstatement and must reapply for coverage as a new group. At that time, the group will be subject to new business underwriting and enrollment guidelines. All past-due premiums must be received in order to be considered for underwriting and enrollment.

OHP and OHIC will require payment of any uncollected premiums owed by the group at the time of termination, and the first month's premium deposit prior to reenrollment.

If a group termination was due to premium payments being returned for insufficient funds, the Plan will require future premiums to be paid with certified funds for a period of 12 months.

Groups that have been terminated three times within a rolling 24-month period will be rewritten as a new group, and will be required to pay all past-due and current premiums and elect auto debit for all future premium payments. Groups not electing the auto-debit premium-payment option will be ineligible to be rewritten as a new business case for a period of one year following their last termination date.

Renewal Proposals

Proposals for renewing groups will be prepared and forwarded to the current Agent or Broker of Record (AOR/BOR) approximately 90–120 days prior to the group's renewal date. Groups will be notified that their renewal information has been forwarded to the AOR/BOR. Complete proposals are not forwarded to the group directly; administrators will receive only the notification of renewal and the proposed renewal rates. It is the responsibility of the current AOR/BOR to deliver and review the proposed rates, benefits, and plan changes promptly to the group. **NOTE:** Groups receiving a **35% or greater** premium increase must receive their renewal rates at least **60** days prior to their anniversary date. Groups receiving **less than a 35%** premium increase must receive their rates at least **30** days prior to their anniversary date.

The AOR/BOR is required to notify their OHP or OHIC Account Executive of the group's renewal decision a minimum of 10 days prior to the anniversary date. In the event the renewal determination is not communicated 10 days prior to the group's anniversary date, OHP or OHIC will automatically renew the group's coverage at the proposed rates. Any requests for Plan changes made after the notification deadline will then be subject to the guidelines outlined in the Plan Changes section of this guide.

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; or
- 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:
  - The amount of the premium paid by each subscriber under the group plan;
  - The amount of the premium paid by the group;
  - The amount of the rebate provided to each subscriber;
  - The amount of the rebate retained by the group; and
  - The 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:

- **Group billing**: Mid-Market (more than 50 total and 150 or fewer eligible employees) 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.
- **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 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

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