



Benefit Administrator Guide

OPTIMA HEALTH BENEFIT ADMINISTRATOR GUIDE

Welcome to Optima Health!

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 and payments should be directed to the Account Services/Finance Department. Eligibility and Enrollment issues should be directed to the Customer Operations/Enrollment Department. The Account Services Department is available Monday through Friday, 8 a.m. to 5 p.m. and may be reached by dialing (757) 687-6400 (press option #1) or toll-free 1-866-472-5764. The Customer Operations/Enrollment Department may be reached by dialing (757) 687-6400 (press option #2).

The Optima Health Plan Web site, optimahealth.com, also serves as a valuable resource for employers and employees. Our Web site allows registered members to perform a number of secure transactions within the health plan. It also provides benefit, health plan and general health-related information. You may access the site 24 hours a day, seven 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!

TABLE OF CONTENTS

GROUP BILLING	3
ELIGIBILITY	4
ENROLLMENT HIGHLIGHTS.....	5
<i>Employee</i>	
<i>Dependent</i>	
ENROLLMENT APPLICATION CHECKPOINTS	6
<i>New Spouse</i>	
<i>Newborn</i>	
<i>Adopted Child/Child in Legal Custody</i>	
<i>Student Verification</i>	
MEMBERSHIP CHANGES	8
<i>Termination Guidelines</i>	
<i>Disenrollment Guidelines</i>	
<i>Reinstatement Guidelines</i>	
CONTINUING COVERAGE	10
<i>Continuation of Coverage during Absence from Employment (COBRA)</i>	
<i>Individual Conversion Policy</i>	
<i>Insurance Portability and Accountability Act of 1996</i>	
HOW TO CONTACT OPTIMA	15
FREQUENTLY ASKED QUESTIONS	16
<i>Register on optimahealth.com</i>	
<i>View claim information</i>	
<i>Prescription drug coverage</i>	
PLANS OFFERED	17

GROUP BILLING

On or around the 10th of each month, the Plan will send a bill for the premiums due on the first day of the following month. For example, a group bill generated in August is due on August 31. Any enrollment changes processed on or after the date that the bill is generated will appear on the next billing statement. The Plan strictly adheres to the prepayment guidelines in the Group Agreement/Policy. In order to allow time for processing, please submit payment at least seven days prior to the due date.

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 appear in the upper left corner. The statement number, statement date (bill generation date), due date and period covered can be found in the upper right corner.
- **The Subscriber Reconciliation List:**
This section details all active subscribers for the current month. Subscriber numbers, Social Security 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 report total ties to the retroactive adjustments on the Group Statement.
- **The Group Reconciliation Statement:**
A form to forward monthly additions and terminations back to the Plan.

Other important billing information:

- **Group billing:**
Group billing is calculated on a full month proration basis. Groups are 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 a Group's coverage.
- **Checks returned for non-sufficient funds:**
Group coverage may also be terminated if a premium check 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 checks 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 two-year period are ineligible for reinstatement.
- **Renewal Bills:**
Each year, during the employer group's anniversary period, the monthly billing is slightly delayed until the anniversary period ends. This is to allow adequate time for re-enrolling the group and subscribers.

ELIGIBILITY

Employee Eligibility

An employee is eligible for Coverage if he/she:

1. is employed by the group; and
2. resides or works in the service area or is an out-of-area employee (and no more than 35% of the eligible and enrolled employees are out of area); and
3. is actively at work performing all of his or her usual occupation duties; and
4. is working regularly at least 25 hours per week, 50 weeks per year; and
5. at least 17 years of age; and
6. within 31 days of the effective date of coverage, files a completed enrollment application with the Plan; and
7. does not knowingly give incorrect, incomplete, or deceptive information regarding his/her eligibility for coverage to the Plan or to the Employer Group; and
8. does not knowingly give incorrect, incomplete, or deceptive information regarding his/her dependents eligibility for coverage to the Plan or to the Employer Group; and
9. meets any other requirements as specified herein, or as specified by the Plan or by the Employer Group.

Please note that new enrollees will be added on the first of the month following the employee's waiting period in accordance with your company's guidelines. Those employees who do not enroll upon completion of their eligibility period must wait until the group's next anniversary/enrollment period to enroll.

Dependent Eligibility

To be eligible for coverage, a dependent must be one of the following:

- The legal spouse of the insured employee.
- The insured employee's unmarried children under 19 years of age who are dependent upon the employee and who are natural children, or legally adopted children or children under the legal custody of the insured. Stepchildren, whether residing with the member or not, are also eligible. Foster children are not eligible. Grandchildren are only eligible with proof of legal guardianship. (Coverage terminates at the end of the month in which the child turns 19 years of age.)
- The insured employee's unmarried children (as defined above) who are enrolled full-time (undergraduates with 12 or more credit hours per semester, graduate students with six or more credit hours per semester) in an accredited university or college, who are not employed on a full-time basis and who are dependent upon the insured employee. (Coverage terminates at the end of the month in which the child turns 24 years of age or is no longer a full-time student.)
- An undergraduate student with 12 or more units of study; or
- A graduate student with six or more units of study. A completed Verification of Student Eligibility Form must be returned to our office within 30 days from the date of letter, otherwise coverage for the dependent child will be terminated.

ENROLLMENT INFORMATION

Eligible employees and their dependents may enroll during the group's open anniversary period or after a qualifying event during the year. However, newly enrolled members may be subject to a twelve month pre-existing condition limitation. Pre-existing conditions will be excluded from coverage for twelve months from the date of enrollment.

A pre-existing condition means a condition (whether physical or mental) regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on the Member's enrollment date. The enrollment date is the first day of coverage under the plan or if there is a waiting period the first day of the waiting period. Services for pre-existing conditions are excluded from coverage for 12 months from the date of enrollment.

Exceptions to the pre-existing condition limitation:

- Pregnancy
- Newborn children who were covered under creditable coverage within 31 days from the date of birth.
- Children adopted or placed for adoption before age 18 who are covered under creditable coverage within 31 days from the date of adoption or placement for adoption.

Creditable Coverage

The pre-existing condition limitation will be reduced by any periods of creditable coverage as long as there has been no break in coverage exceeding 63 days.

Examples of creditable coverage include:

- Another group health plan (including COBRA)
- Individual coverage
- Medicare or Medicaid
- CHAMPUS
- Medical care program of the Indian Health Service or of a tribal organization
- A state health benefits risk pool
- A public health plan
- A Peace Corps health plan

At the time of enrollment, members with creditable coverage must submit a Certificate of Creditable Coverage from the previous insurer or employer with their enrollment application.

ENROLLMENT APPLICATION CHECKPOINTS

The information requested on the Enrollment Application/Coordination of Benefits/Health Questionnaire is essential to ensure coverage for a new member, accurate billing, and coordination of benefits with other insurance carriers. All information on the Application must be complete before submission for processing. Applications may be faxed to (757) 552-7199 or e-mailed to www.small_group_enrollment@sentara.com. Please notify your broker/agent of any change. A short summary of major checkpoints is included below for various situations.

(1.) Adding an Existing or Newly Hired Employee

- Employee has completed eligibility waiting period.
- Enrollment Application/Coordination of Benefits Health Questionnaire is completed.
- Employee's Date of Hire and requested effective coverage date is indicated on Application.
- Group/subgroup number is provided on Application.
- Any necessary documentation is attached.
- Certificate of Creditable Coverage for employee and all covered dependents is provided.
- Application is signed by Benefits Administrator and employee.

(2.) Adding a Spouse

- Enrollment Application with effective date of coverage/Coordination of Benefits/Health Questionnaire is completed.
- Copy of marriage certificate is attached.
- Application is signed by Benefits Administrator and employee.

(3.) Adding a Newborn (Application must be received within 31 days of birth.)

- Enrollment Application with effective date of coverage/Coordination of Benefits/Health Questionnaire is completed.
- Date of Birth is indicated on Application.
- Application is signed by Benefits Administrator and employee.

(4.) Adoption or Legal Custody of a Child

- Enrollment Application with effective date of coverage/Coordination of Benefits/Health Questionnaire is completed.
- Date of adoption/court order is indicated on Application.
- Copy of adoption papers or custody order is attached.
- Application is signed by Benefits Administrator and employee.

NOTE: A dependent added as a result of adoption or a custody decision is defined as (i) a legally adopted child; (ii) a child for whom the subscriber or spouse has temporary or permanent legal custody; (iii) a child for whom the subscriber must provide benefits as the result of a court order. Foster children will not be considered as eligible dependents.

ENROLLMENT APPLICATION CHECKPOINTS

Completed applications and necessary attachments should be mailed to: Optima Health Enrollment Department, 4417 Corporation Lane, Virginia Beach, Virginia 23462.

(5.) Additional Enrollment Documentation

In the following situations, additional information/documentation is required to complete the enrollment process:

(a.) Dependents Age 19 and Over Attending School on a Full-Time Basis:

Submit documentation from the institution showing your dependent is enrolled; or complete a Student Verification Form which may be obtained by calling Member Services. Dependent(s) are not covered until required documentation is received.

(b.) Handicapped Dependents Age 19 and Over:

The Subscriber must give the Plan acceptable proof of incapacity and dependency within 31 days of the child reaching the specified age. Proof of incapacity consists of a statement by a licensed psychologist, psychiatrist, or other physician, verifying the dependent is incapable of self-sustaining employment by reason of a mental or physical disability. The Plan may require subsequent statements not more than once a year.

(c.) Loss of Coverage:

Individuals who have lost their previous health insurance coverage must include the Certificate of Creditable Coverage with their completed and signed enrollment application.

MEMBERSHIP CHANGES

Your employees may visit the Plan's Web site at optimahealth.com or call Member Services at the phone number on their I.D. card to:

- Change Primary Care Physician (PCP) if plan requires PCP designation
- Change Address and/or Telephone Number
- Order a new Member I.D. card
- View and print commonly requested forms
- View claim status, referrals and authorizations
- Change Name
- Change in Dependent Status
- Divorce (if the spouse was enrolled on the plan)

TERMINATION / DISENROLLMENT / REINSTATEMENT

(1.) Termination Guidelines

The group shall notify Optima, in writing, on or before the 15th of the month, of any member who has become ineligible for coverage. Upon receipt of notification, Optima may credit any premium payments received from the Group, on behalf of a terminated member, back to the requested termination date (not to exceed 60 days). If a member has incurred claims, termination will be the last day of the month in which the last claim occurred.

- e.g. If notification is received by January 15th for a requested termination date of November 30th and no claims incurred, Optima will authorize retro termination and credit the January and December premiums on the group's next billing cycle.

If notification is received after January 15th for a requested termination, and no claims incurred, Optima will authorize credit of the January and February premiums which have been billed.

If requests for retroactive terminations are received after 180 days of the requested termination date, the termination will be processed on the next eligible disenrollment date and no credit premium will be allowed. Optima will not credit a group any premium payments associated with members who have incurred claims during the period of ineligibility.

(2.) Disenrollment Guidelines

Subscribers

- Follow the termination guidelines outlined above.
- Submit a written request of termination to the Plan in one of the following ways:

Fax or mail a request to the Plan on company letterhead. Provide member name, member number, and the requested date of termination.

- (a.) Complete an Enrollment Application by marking the box titled "cancel all" and indicate the requested date of termination.
- (b.) Indicate the name of the terminated subscriber and the date of termination on the Group Reconciliation Statement section of the bill.

MEMBERSHIP CHANGES

Spouse and/or Dependents

- Follow the termination guidelines outlined above.
- Submit a written request of termination to the Plan in one of the following ways:

Fax or mail a request to the Plan on company letterhead. Provide member name, member number, and the requested date of termination.

- (a.) Complete an Enrollment Application by marking the box titled “cancel spouse/dependent.” Indicate the name of the spouse/dependent. Mark the “delete” box for the spouse/dependent being removed, and indicate the requested date of termination.

(3.) Reinstatement Guidelines (Completed application required)

- An employee who returns to work within 90 days after an approved leave of absence will keep the same employment and eligibility status as before.
- An employee who returns to work after 90 days will be considered a new employee and will be subject to all eligibility requirements, including any pre-existing condition exclusions, waiting periods, and effective date of coverage requirements.

CONTINUING COVERAGE

Continuation of Coverage During Absence From Employment

If a subscriber is no longer actively employed because of one of the following circumstances, coverage may continue for:

- A period not longer than 90 days for an approved leave of absence.
- A period not longer than 180 days due to total disability.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a Federal law which states that employers of 20 or more employees maintaining a health care 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 less than 20 employees
- Federal government and the District of Columbia
- Church plans

The Plan agrees to provide continued health care services which will enable the Group to comply with the requirements of COBRA, including the changes made under the Health Insurance Portability and Accountability Act of 1996 signed into law August 21, 1996, 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.

- 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.

CONTINUING COVERAGE

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. We are providing information in an attempt to help with compliance only. If additional advice or information is needed, we suggest contacting 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.
- Bill the employer for all COBRA participants under a COBRA subgroup.

Individual and Family Health Plans

Employees and dependents who are no longer eligible for coverage through an employer group, may within 31 days of termination of coverage, convert to an Individual or Family Health Plan. Individual and Family Health Plan applications are available by calling the Individual Sales Center at 1-866-532-7713. Inquiries or additional information may be obtained by contacting the Individual Sales Manager at (757) 552-7368. Information is also available through the Plan’s Web site optimahealth.com/individual.

Individual Conversion Policy

Employees who are no longer eligible for coverage through the employer group, may within 31 days of termination of coverage, convert to an individual conversion policy. Individual conversion applications are available to members by calling the Member Services Department.

Conversion Privilege is also extended to:

- The spouse of an enrolled member who ceases to be eligible by reason of death of the member or divorce.
- The child of an enrolled member who ceases to be an eligible dependent.

Medicare

Optima Health offers a Medicare Advantage plan (Optima Medicare) to all eligible Medicare beneficiaries. For more information regarding the Medicare plans offered by Optima Health, log on to optimahealth.com/medicare or call Member Services at 1-800-927-6048.

HIPAA

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

To comply with the joint responsibility given employers and insurance issuers under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Optima Health provides Certificates of Creditable Coverage to members who lose coverage. These certificates are mailed to members approximately seven to ten days after Optima Health receives notice of coverage terminating. There is no charge for this service.

You, as the employer, will retain the responsibility for supplying the employee with certification of the beginning and end of any waiting period that must be met prior to being eligible for coverage. In addition, if your employee/former employee had coverage through Optima Health for less than 18 months, it is your responsibility to assist this person in obtaining the Certificate from their previous insurer. Optima Health can only confirm health coverage which was issued by our company.

Following is a sample certificate.

Certification of Group Health Plan Coverage

1. Certificate Date: <Date Letter Generated>
2. Name of Group Health Plan: <Name of employer group>
3. Name of Participant: <Member Name>
4. Identification Number of Participant: <Member ID#>
5. Name of Individual to whom this Certification applies: <Member Name>
6. Plan Administrator or issuer responsible for providing this Certification. Optima Health Plan, 4417 Corporation Lane Virginia Beach, VA 23462
7. For further information call: <Member Service Phone Number>
8. <Member Name> has (or has not) had at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break).
9. General group waiting period: <Group Lag HC310 field 11>
10. Date Coverage Began: <Member Effective Date with Current Group listed in item #2>
11. Date Coverage Ended: <Member Term Date with group listed in item #2 if not termed use place the word Continuing>

[Note: Separate certificates will be furnished for each family member]

Statement of HIPAA Portability Rights

IMPORTANT – KEEP THIS CERTIFICATE. This certificate is evidence of your coverage under this plan. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a Pre-existing condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems.

Pre-existing condition exclusions. Some group health plans restrict coverage for medical conditions that are present before an individual's enrollment. These restrictions are known as "pre-existing condition exclusions." A pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a pre-existing condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a pre-existing condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a pre-existing condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

- Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any pre-existing condition exclusion if you enroll in another plan.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a pre-existing condition exclusion. To be an eligible individual, you must meet all of the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.
- The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.
- Therefore, if you are interested in obtaining individual coverage and you meet all the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

State flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws.). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: <http://www.dol.gov/ebsa>, the DOL's interactive web pages – Health Elaws, or <http://www.cms.hhs.gov/hipaal>.

HOW TO CONTACT US

Web site

Visit the Plan's Web site, optimahealth.com, to:

- View a list of participating providers
- Change primary care physician (PCP)
- Update home address, phone number or e-mail address
- Order a new member I.D. card
- View claims history and authorizations
- View benefits
- Download member forms
- Learn about member discounts
- Manage pharmacy benefit (if administered by Optima Health)
- Research drug options and pricing
- Opt to receive Explanation of Benefits (EOB) online
- Research conditions, treatment options and hospital quality

You will need to register on optimahealth.com to access specific member information as well as special tools available only to Optima Health Plan members.

Phone

Member Services (757) 552-7401 or 1-877-552-7401:

Call the number listed on your Member I.D. card or (757) 552-7401 (or 1-877-552-7401 toll-free). Office hours are Monday through Friday, 8 a.m. to 7 p.m. After business hours, please leave a message.

TDD lines for the hearing impaired/AT & T Language Line (757) 552-7120 or 1-800-225-7784:

For limited or non-English speaking members.

After Hours Nurse Advice Line (757) 552-7250 or 1-800-394-2237:

Call the After Hours Nurse Advice Line if you need information on where to seek care for illnesses or injuries occurring nights, weekends or holidays.

Mail

Optima Health
4417 Corporation Lane
Virginia Beach, VA 23462

Frequently Asked Questions and Answers about optimahealth.com

How to register on optimahealth.com?

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

If you are a Sentara employee and have an Optima Health plan (even if your coverage is not through Sentara Healthcare), you do not need to register. Simply use your network sign-in to access secure areas of the Web site.

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 to have your password reset.

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

Contact Member Services at the number on the Member I.D. card or online through our “Contact Us” form.

How do I know my information is safe/secure?

We are required by law to:

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

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

How do I allow my spouse to view my claims?

Easy. Simply register and sign in to optimahealth.com. Once you are signed in, you will notice a check box option on “View Medical Claims” and “View Referrals/Authorizations.” If you elect to allow your covered spouse to view your information, he/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 of covered dependents under the age of 18. These self-service functions include view claims, view referrals/auths, change contact info, change PCP and view summary of benefits.

How can I access my child’s pharmacy claims?

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

How do I know if my prescription drug is covered?

You can search our drug lists using the Drug Search Tool located in the upper right hand side of the screen under Search Tools. Covered members may also sign in to determine coverage and exact copay amount using the “Pharmacy Resources” link located on the left-hand *MyOptima* menu.

Where do I find benefit information?

Sign in to view the Summary of Benefits in the *MyOptima* menu.

PLANS OFFERED

Optima Health offers several different plan options to meet our customers' needs. This Benefit Administrator Guide outlines basic information to common questions about the health plans available. Specific plan information such as copay, coinsurance and applicable deductibles are referenced in the specific plan benefit, a benefit structure that is chosen by the employer.

Please note some plans may not be available in all service areas. Contact the current agent or broker for further information regarding plan options.

Optima Vantage

Open access model Health Maintenance Organization (HMO) plan that allows members to seek special care for covered services without a referral. Under the Vantage plan, a Primary Care Physician (PCP) is chosen and coordinates the member's healthcare needs. Consult the PCP for routine medical assistance or guidance when seeking care within the Optima Health network.

Optima POS

An open access point-of-service (POS) Plan in which a Primary Care Physician (PCP) is chosen to coordinate the member's healthcare needs, but does not require referrals for Plan specialist care. Consult the PCP for routine medical assistance or guidance when seeking care within the Optima Health network. Also, the POS plan allows the option to receive covered services from an out-of-network provider by using out-of-network benefits.

Optima FourSight

A unique plan that gives members a limited number of up-front benefits before a deductible has to be met. When members need more than the up-front benefits, FourSight covers a set percentage of the plan's schedule after an annual deductible has been met. In addition, the plan features in-network and out-of-network benefit options.

Optima Equity

A preferred provider organization (PPO) with a high-deductible health plan (HDHP) that lets members contribute to an HSA. Employees are eligible to make pre-tax contributions to the HSA account.

Optima Plus

Designed to give members flexibility when choosing providers for care; offers in-network and out-of-network benefit options.

In-network:

The in-network benefit option means you can lower your out-of-pocket costs by seeing Plan doctors, specialists, therapists and other healthcare professionals who have met all of Optima Health's credentialing requirements, and are part of the provider network.

Out-of-network:

If you choose to use your out-of-network benefit option for covered services, it means you and your family members can select any doctor or medical facility you want, regardless of whether or not they are Plan providers. Remember, your out-of-pocket costs will be higher when using your out-of-network benefits.

PLANS OFFERED

Optima Individual and Family Plans

Whether in school; self-employed; between jobs; ready to retire; have a family, or do not have health care coverage through an employer, Optima Health has medical coverage that meets those unique needs.

For additional information, current Individual and Family Health plan members may contact Customer Service at (757) 552-7274 or 1-866-514-5916. For questions regarding new sales inquiries and quotes, please call 1-866-532-7713 or visit the Web site optimahealth/individual.com. General inquiries regarding individual health plans may also be directed to individualsales@sentara.com.

Optima Medicare Plans

Optima Health offers a Medicare Advantage plan (Optima Medicare) to all eligible Medicare beneficiaries age 65 and over. For more information regarding the Medicare plans offered by Optima Health, log onto optimahealth.com/medicare or call Member Services at 1-800-927-6048.

Family Access to Medical Insurance Security Plan (FAMIS)

Family Access to Medical Insurance Security Plan (FAMIS) is a program administered by the Commonwealth of Virginia that extends health insurance coverage to uninsured children under age 19.

Optima Family Care

Family Care is a health plan that will work in partnership with the Commonwealth of Virginia to provide the benefits of the FAMIS Plan. Family Care is a Health Maintenance Organization (HMO), committed to providing courteous, professional, and quality care. For additional information regarding Optima Family Care, please call Member Services from 8 a.m. until 7 p.m., Monday through Friday at (757) 552-8975 or 1-800-881-2166.

NOTES

OptimaHealth 

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