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2018

Benefits Administrator

OFFICE GUIDE

Small Group

2-50 Total Employees

OptimaHealth

BENEFITS ADMINISTRATOR OFFICE GUIDE

SMALL GROUP (2–50 TOTAL EMPLOYEES)

v. 1017

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, also serves as a valuable resource for employers and employees. Our website allows registered members to perform a number of secure transactions within the health plan including the ability to request member ID cards, view billing statements, and pay monthly invoices 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.

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Segment Determination

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

1. How many total employees (full time and part time) does the group have?
    a. If 50 or fewer, it is a small group and not medically underwritten.
    b. If 51 or more, see #2 below.
2. If 51 or more total employees, how many are eligible for group coverage?
    a. If fewer than 151 are eligible, the group is mid-market and underwritten.
    b. If 151 or more are eligible, the group is underwritten in large group.

Employer, 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)
- Organizations with at least two eligible employees (includes owners and partners; excludes COBRA participants), but not more than 50 total employees
- 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 public/private exchange may be exempted.

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

Eligible Employees

An employee is eligible for coverage if he/she:

- Is employed by the group;
- 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);
- 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; and
- Meets any other requirements as specified herein, or as specified by the Plan or by the employer group.

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

Self-employed proprietors, directors, or partners of a company are not excluded, provided they meet the criteria listed above. Sole proprietors, directors, partners, or principals for any two-person group, or any other group not required or able to submit a VEC Quarterly Wage and Earnings Report will be required to submit one or all of the following:

- Declaration letter attesting 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; or
- Payroll summary.

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 Optima Health Plan (OHP) or Optima Health Insurance Company (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.**

Employees NOT Eligible

- Independent contractors (1099) of the employer
- Part-time employees who work less than the minimum hours required by the Plan or the employer, which cannot be any less than 25 hours per week; or leased, temporary, or seasonal employees
- Directors and officers not otherwise eligible as active, full-time employees
- Retirees or pensioned employees

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

Spousal Partners

A group with spousal partners and no other employees is not eligible for group coverage. The business must have at least one other employee to be eligible for group coverage.

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 Out-of-Area (OOA) Preferred Provider Organization (PPO) plan. No more than 35% of the covered employees can be covered under the OOA PPO. If more than 35% of the group's covered employees are outside of the service area, the group will either be quoted without the OOA employees or Optima Health will be unable to provide a quote for the entire group.

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

Eligible Dependents

- The legal spouse of the insured employee
- 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, and
  - Other children for whom the subscriber is a court-appointed legal guardian. Grandchildren are only eligible with proof of legal guardianship.

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, or
- 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.

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, and
- 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 disenrolled 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, disenroll the subscriber/dependent, and retract all or part of any claims paid from the provider(s) during the period of ineligibility. Disenrollment 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 disenroll 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, or
- Health Information Portable Care Act of 1996 (HIPAA) "Special Enrollment Provisions."

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

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

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

- Become eligible for assistance with respect to coverage under a Medicaid, or CHIP plan (including any waiver or demonstration project conducted under such plan)
- **Lose eligibility under Medicaid or CHIP coverage.** The employer is required to provide employees notice of special enrollment rights and premium assistance under CHIP. In both cases the employee must request special enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

Effective Date of Coverage

Subject to the Plan's receipt of 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 he or she satisfies 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 he or she satisfies 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 he or she is 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 his or her 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. 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 his or her 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 he or she is under age 65, entitled to Medicare because of End-Stage Renal Disease (ESRD), and have employer group health coverage, the covered person should contact the Plan regarding participation with Medicare Part B or assistance in obtaining Part B.
- **Part-time to Full-time Status Change.** Coverage of employees whose employment status changes from part time to full time is effective on the first day of the month following the date of the status change, provided any eligibility waiting period has expired. The eligibility waiting period begins on the employee's first day he or she moves from part-time to full-time status.
  - If an employee is reinstated to a full-time status role within three months of moving to part-time, being laid off, and/or being terminated, he or she 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, he or she is subject to the new-hire eligibility waiting period guidelines.

Policies/Procedures for Groups Applying for Coverage

Employer Contribution

There is no minimum employer contribution level in small group.

Principal Ownership Companies

Principal ownership companies are eligible, given the following stipulations:

- There must be a consistent principal owner in all companies (i.e. the same individual holds the largest stake in each company. A 50% stake in a 50/50 ownership is acceptable).
- Multiple-partner companies must provide documentation of partnership arrangements—as well as written documentation—signed by all partners, outlining parties eligible to authorize changes to the group's employee benefit package and broker arrangements.
- There must be a clear and demonstrable relationship to each of the sub-companies.
- All of the employees will be used to determine rating and plan selection.
- Each company must maintain the same eligibility requirements, employer contribution, and benefit plan.
- At any time the group requests to divide the companies into separate group plans, the group will be re-underwritten using current quarter rates. Each company will be separately evaluated to determine an appropriate rating level and given a new contract period. Additional documentation may be requested, such as waivers and/or applications or health questionnaires, from any employee not currently enrolled in the group's plan.

Class-Based Waiting Periods/Employer Contributions

Groups may elect to have different new-hire waiting periods and/or employer contributions for different classes. The effective day must be the first day 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.

Participation Requirements

Firms with only two or three employees are required to have 100% participation. Groups with four or more are required to have 70% participation of eligible employees. Employees who waive coverage to stay on another qualifying plan (such as Medicare, TRICARE/CHAMPUS, or a spouse's employer-sponsored plan) are not considered eligible employees for the purpose of the participation calculation, and will not count against the group's participation. To determine group participation:

ABC Company	30	Total eligible employees (all full-time employees working 25+ hours weekly)
	-10	Employees enrolled on their spouses' or other plan (must have waiver)
=	20	Eligible employees to be counted toward participation requirement

Participation of 70% would require that 14 of the 20 potential enrolling employees participate in the Plan. Participation is a continuing requirement. Participation requirements must be met at the time the group is underwritten, and throughout enrollment under the Plan(s). Failure to maintain required participation levels may result in termination of the group at any time the participation falls below the required level. Renewal of a group may be contingent upon re-verification of group's employee participation.

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

Employee Application

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

Each employee in a current group applying for coverage must complete an Employee Application. The Application must be completed and signed by the employee and BA. When requesting coverage for dependents, their enrollment must also be provided. NOTE: All sections of the Application must be completed prior to submission. Incomplete applications may be returned to the employee for completion and may delay the enrollment process.

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

Employees who decline coverage for any reason and later decide they want to apply for coverage will be able to do so at the next open enrollment opportunity or if a qualifying event qualifies the employee for a Special Enrollment.

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

Waivers

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

- Self, which will include all dependents;
- Spouse only;
- Child or children only;
- Spouse and child or children; or
- 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, groups applying for coverage must also supply a copy of the group's most recent Virginia Employment Commission (VEC) Quarterly Wage and Earnings Report.

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

- Full time (FT),
- Part time (PT) (must work at least 25+ hours weekly to be eligible),

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

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 must 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; or
- Payroll summary.

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

Misstatement of Age or Class

If the age or level/tier of coverage of any insured employee has been misstated, the member's correct age or level/tier of coverage shall determine the amount payable under the 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.

Premium Check/Payments

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

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

Work-Related Illness and/or Injury

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

Guidelines/Policies/Procedures

Small Group New Business

Small Group is considered to be employer groups with 2–50 total employees. The total employee count includes all full-time and part-time employees.

Please allow no less than five business days for the completion of enrollment. Return of incomplete applications to the group/employee may also cause delays in the enrollment process. Please ensure that the correct application has been used based on the segment (size) of the group and the applicable product, and that 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 applications to Optima Health prior to the close of business by the fifth of the effective month. All additional information necessary for enrollment will need to be completed prior to the close of business on the tenth of the effective month.

Groups requesting a fifteenth-of-the-month effective date will need to submit applications to Optima Health prior to the close of business by the twentieth of the effective month. All additional information necessary for enrollment will need to be completed prior to the close of business on the twenty-fifth of the effective month.

Items required to complete the enrollment process include:

- Employer Group Application
- Complete Employee Applications for every employee who is applying for coverage. Applications must be signed and dated by applicant. NOTE: Any applications signed more than 90 days prior to the effective date will require a new, updated application.
- Waivers for eligible employees who are not electing coverage
- VEC, declaration letter, or other required eligibility documentation

ACA Age or Composite Rates for New Business Cases

The ACA now allows for composite rating in the small group segment. Groups may choose between one-year age-banded rates or composite rates. The default approach will be age-banded rates. If the customer wants composite rates, this should be confirmed in writing via email confirmation, or a note on the Group App for new business.

Risk Acceptance

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

Omission of information on the Employee Application 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 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, or
- Violation of participation or contribution rules.

Additional Requirements/Information

Groups requesting two plan offerings must have a minimum of two enrolling employee subscribers. Groups requesting three plan offerings must have a minimum of 15 enrolling employee subscribers, or two enrolling employee subscribers if the third option is an Equity Consumer-Directed Health Plan (CDHP). Note: HMO plans are not available in all service areas.

Companies originally written as a small group (2–50 total employees) that increase their total employee count to 51 or more employees during the contract year will remain small group until renewal. At renewal, such groups will be reviewed on a case-by-case basis to determine their status. The same review will apply to groups that fall below 51 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 issued a new 12-month contract period using the current quarter's rates. Additional documentation may be requested, such as waivers and/or Applications, from any employee not currently enrolled in the group's plan.

Under-Contract Groups

Under no circumstances can the size of the group fall below two enrolled employees. A group falling to only one contract may have until the group's renewal date to achieve two contracts or they will be canceled.

If the group receives a cancellation notice at renewal, and if minimum participation is not increased prior to the renewal date, the notice of termination of coverage will stand.

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. Applications 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 must be signed by the applicant and submitted within 30 days of the requested effective date.

Retroactive Disenrollment

Other than for a Rescission of Coverage for fraud, Optima Health can only terminate a member's coverage 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 Affordable Care Act (ACA) and all state Health Reform conditions for retroactive termination of coverage have been met. The Plan may examine the group's records relating to the coverage under this agreement during normal business hours at a location mutually agreeable to the group and the Plan. ACA means the Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and as it may be further amended.

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 days prior to the group's renewal date. Groups will be notified approximately 30 days prior to their effective date 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.

ACA Age or Composite Rates

The ACA allows for composite rating in the small group segment. Groups may choose between one-year age-banded rates or composite rates. The default approach will be age-banded rates. If the customer wants composite rates, this should be confirmed in writing:

- Via email confirmation, or
- A notation on the Group Information Summary for existing business.

If census changes between the quote date and the plan effective date such that premium changes by 10% or more, the composite rates may be re-calculated using the new census.

Continuation of Coverage

Continuation of Coverage during Absence from Employment

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

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

Consolidated Omnibus Budget Reconciliation Act of 1985

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

- Employers with less 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 (2–50 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 Statement

A group bill consists of four parts, if applicable:

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

Other important billing information:

- **Group billing**: Large group (151+) Group billing is calculated on full/half or daily proration, based on the group's selection at contract set-up.
- **Grace period:** The Plan allows a 31-day grace period for the payment of premiums. Failure to pay premiums within the grace period may result in termination of your group's coverage.
- **Payments returned for non-sufficient funds**: Group coverage may also be terminated if a premium payment is returned for non-sufficient funds. If a group is reinstated following a non-sufficient fund termination, future premiums must be paid with certified funds. A $25 service charge will also be applied for payments returned for this reason.
- **Reinstatement:** The Plan will allow for reinstatement of a group health plan with payment of all past due and current premiums within 15 days of the date of termination. Groups that have been terminated for non-payment three times in a 24-month period are ineligible for reinstatement.
- **Renewal Bills**: Each year, at the employer group's anniversary period, the monthly billing will be slightly delayed until the anniversary period ends. This is to allow adequate time for re-enrolling the group and subscribers.

EMPLOYEE CONTACTS AT A GLANCE

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

Online

Visit optimahealth.com to:

- View a list of Plan providers
- Change your Plan primary care physician (PCP)
- Update your home address, phone number, or email address
- Order a new Member ID card
- View your claims history
- View your benefits
- View your authorizations
- 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
- Access MDLIVE

You will need to register on optimahealth.com in order to access your secure member information as well as special tools available only to Optima Health members.

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

Mobile

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 lines for the hearing-impaired

1-800-225-7784 or 757-552-7120

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

MyOptima Mobile App

MyOptima—the Optima Health mobile app—goes with you wherever you take your smartphone.

A tap of the screen and you can find doctors and urgent care centers, and shop for health plans. Members can also securely view benefit information, member ID cards, claims information, and their user profile. You must be registered on optimahealth.com prior to using the app's secure features.

MyOptima can be downloaded from the App Store or Google Play for use on an iPhone or Android™.

Employee Frequently Asked Questions (FAQs)

How do I 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 ID card is needed when registering.

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

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

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

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

How do I know my information is safe/secure?

We are required by law to:

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

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

How do I allow my spouse to view my claims?

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

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

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

How can I access my child's pharmacy claims?

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

How do I know if my prescription drug is covered?

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

Where do I find benefit information?

Sign in to view your Summary of Benefits and Uniform Summary of Benefits and Coverage documents in the *MyOptima* menu.

Optima Health
4417 Corporation Lane
Virginia Beach, VA 23462

757-687-6030 Local Hampton Roads
1-877-552-7401 Toll-free for Hampton Roads
1-866-575-4475 Toll-free for Virginia Statewide

757-687-6031 Fax

www.optimahealth.com