Commercial Broker Guide

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INTRODUCTION

At Optima Health, we are proud to partner with you in growing your business. We continue to expand and grow our membership, thanks to all of you. Each day we strive to make it easier for our brokers 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 for your clients, especially as the economy changes. We appreciate the trust you place in us each time you recommend us to your clients.

The Optima Health Broker Guide will provide you with procedural information on how we address some of the more common questions and underwriting subjects. Our underwriting philosophy equates to a good business practice equation—one profitable to the company, valued by the member, and complimentary to the agent's portfolio of products. The Guide reflects our best efforts to align our policies and procedures with our understanding of current federal and state requirements. If you have additional questions that are not covered in this Guide, please contact your Optima Health representative for further assistance.

All of us at Optima Health look forward to continuing to grow our businesses together. Thank you for making Optima Health the right choice for your clients.

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Segment Determination

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.

Small Group
Enrollment Guidelines

Employers, Employee, and Dependent Eligibility

Eligible Employers

- Corporations and partnerships with a clear employer/employee relationship, self-employed individuals, or sole proprietorships
- Organizations with at least one eligible employee (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 30 hours per week;
    - Part-time employees working less than 30 hours per week are eligible employees at the employer's discretion.
- 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.

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.**

Self-Employed Individuals

The Virginia Small Employer definition includes self-employed individuals. A self-employed individual means an individual who derives a substantial portion of his income from a trade or business:

- operated by the individual as a sole proprietor;
- through which the individual has attempted to earn taxable income; and
- for which the individual has filed the appropriate Internal Revenue Service Form 1040, Schedule C, E, or F, for the previous taxable year.

The definition of Small Employer includes how to determine whether a corporation or limited liability company (LLC) employed an average of at least one individual during the preceding calendar year and employed at least one employee on the first day of the plan year. It states that an individual is considered an employee of the corporation or the LLC if the individual performed and received compensation or pay for any service under a contract of hire, written or oral, express or implied, for:

- a corporation of which the individual is its sole shareholder or an immediate family member of such sole shareholder, or
- an LLC of which the individual is its sole member or an immediate family member of such sole member.

Self-employed individuals, including sole proprietors, directors, partners, or principals for any one-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, or
- Payroll summary.

Additional documentation required:

- C Corporation: most recently filed W2 form or VEC
- Sole Proprietor: IRS 1040 Schedule C, E, or F
- Partnership, S Corporation, or LLC: most recently filed IRS Schedule K1 (Form 1065 or 11205)

1099 Employees

Optima Health Small Group employers may include 1099 employees on the group health plan.

The following criteria must be met:

- 1099 employees cannot exceed 50% of the group's total eligible employees.
- All 1099 employees must be employed year round, on a full-time basis.
- 1099 employees are subject to the same eligibility and waiting-period requirements, as well as employer contribution amounts, as W-2 employees.
- At least two W-2 employees must be enrolled in coverage.
- Employers must complete an Eligibility and Attestation Form, and submit with the census and other required paperwork for verification. This form is available in eBroker.

Spousal Partners

A group with spousal partners, where both are owners of the corporation or both are partners in an LLC, and there is no sole shareholder or sole member and thus no employees under the law, are not eligible for small group coverage. However, if either of the owners is the sole shareholder of the corporation or sole member of the LLC, then that owner and an immediate family member of that owner could qualify as employees and coverage can be obtained under Small Group plan.

Employees NOT Eligible

- Independent contractors (1099) of the employer, except as noted in the above section
- Part-time employees who work less than the minimum hours required by the employer, which cannot be any less than 30 hours per week; or leased, temporary, or seasonal employees unless they meet criteria for coverage as a 1099 employee.
- 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.

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 dis-enrolled from the Plan.

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

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

Member Plan Changes

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

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

- Eligibility after completion of new-hire waiting period,
- Loss of coverage under another plan,
- Reduction in hours,
- Reasons defined by Section 125 guidelines, 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

Groups 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 30+ 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.

Groups with valid waivers that leave only one enrolling employee will be allowed to enroll and/or renew their health coverage. These one-person groups are not considered Sole Proprietors and must follow all other Small Group policies and procedures.

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

Employers with one or two employees are not required to maintain a Workers' Compensation policy. Claims for work-related illness/injury for enrolled employees of a one- or two-person group would be covered according to the Plan guidelines.

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

Guidelines/Policies/Procedures

Small Group New Business

Small Group is considered to be employer groups with 1–50 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 all information necessary for enrollment 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 all information necessary for enrollment 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 (1–50 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 should the size of a small employer group fall below two enrolled employees (excludes self-employed individuals). 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 Dis-Enrollment

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.

Business*EDGE*® and Business*EDGE* elite™
Enrollment Guidelines

Business*EDGE*® (10–150 total employees) and Business*EDGE* elite™ (10–50 enrolling employees) Enrollment Guidelines

Employers, Employee, and Dependent Eligibility

Eligible Employers

- Corporations, partnerships, or sole proprietorships with a clear employer/employee relationship (1099 employee relationships and disabled workers are not eligible for group coverage)
- For Business***EDGE***®: financially stable business organizations with 10–150 total employees (including owners and partners), and has 10–150 enrolling employees; employers/companies who have not declared bankruptcy or exited bankruptcy in the last five years

  For Business***EDGE*** **elite™:** financially stable business organizations with 10–50 total employees (including owners and partners), and has 10–50 enrolling employees; employers/companies who have not declared bankruptcy or exited bankruptcy in the last five years
- Employers with a payroll-deduction system established for employee contributions
- Groups that file a Virginia Employment Commission (VEC) Quarterly Wage and Earnings Reports
- Employer groups not formed for the sole purpose of securing insurance
- Employer groups located within the Optima Health service area
- Employer groups that have been in business for at least one year
- Carve-outs may be allowed and are subject to non-discrimination rules and policies

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

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

Eligible Employees

An employee is eligible for coverage if 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 at least 17 years of age, works at least 25 hours per week, and works and receives salary for 50 weeks or more per year.
- Is a U.S. citizen who possesses a Social Security number;
- Is a legal alien who has possession of a green card as well as a Social Security number;
- 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 or health history 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 or health history 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.

Business*EDGE*® (10–150 total employees) and Business*EDGE* elite™ (10–50 enrolling employees) Enrollment Guidelines

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

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

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

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

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

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

Out-of-Area Employees

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

The networks used for the PPO products, which provide access to in-network providers, are the OHIC PPO network and a contracted national 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.

Business*EDGE*® (10–150 total employees) and Business*EDGE* elite™ (10–50 enrolling employees) Enrollment Guidelines

Employees NOT Eligible

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

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

Eligible Dependents

- 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.

Out-of-Area Dependents

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

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

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

Dependents NOT Eligible

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

Dependent Verification

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

- Birth certificate,
- Marriage certificate,
- Adoption certificate or proof of placement, 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 dis-enrolled from the Plan.

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

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

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

Member Plan Changes

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

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

- Eligibility after completion of new-hire waiting period,
- Loss of coverage under another plan,
- Reduction in hours,
- Reasons defined by Section 125 guidelines, 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 (Qualifying Life Events)

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

- 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 30 days from the date of a triggering event for qualified employees or dependents who:

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

Effective Date of Coverage

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

- **Effective Date of Coverage.** Coverage under this agreement for a subscriber eligible for coverage on the initial effective date of this agreement becomes effective on the effective date of the agreement.
- **Multiple Coverage.** A subscriber is not eligible to be the subscriber on more than one policy with the Plan even if 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.
- **Subscriber Coverage—Addition to an In-Force Plan**
  - When a person completes an Employee Enrollment 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 an Employee Enrollment 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.
- **Newborn Children.** Newborns will be covered from the moment of birth for 30 days, if the subscriber's coverage under the Plan is in effect. In order for coverage to continue beyond 30 days, the subscriber must add the newborn to his or her coverage within 30 days of birth. An adopted child whose placement has occurred within 30 days of birth will be considered a newborn child of the subscriber, as of the date of adoptive or parental placement. If the newborn is not added to the Plan within 30 days of birth, the newborn may not be eligible to enroll until the next Plan open enrollment period.
- **Adopted or Foster Children.** An adopted or foster child will be eligible for coverage from the date of placement with an eligible subscriber for the purpose of adoption or foster care. An adopted child whose placement has occurred within 30 days of birth will be considered a newborn child of the subscriber as of the date of adoptive or parental placement. Evidence of placement and any applicable premiums must be submitted to the Plan within 30 days from the date of placement. If the adopted or foster child is not added to the Plan within 30 days of placement the child may not be eligible to enroll until the next Plan open enrollment period.

- **Coverage Mandated by Court Order.**
  - If an employer is court ordered by a Qualified Medical Child Support Order (QMCSO) to provide healthcare coverage for a dependent, and the employee does not currently carry healthcare coverage, the Plan will allow both the employee and court-ordered dependent to enroll within 30 days of the date of the court order (with proper documentation), provided the employee has met his or her eligibility period.
  - The effective date may be the first of the month following receipt of the court order by the Plan Administrator, or the date the Plan Administrator notified the state on the "Employer Response Page" that is returned to the state. The group must attach a copy of the Employer Response Page with the court order. If allowed to enroll in healthcare coverage, the employee must enroll the dependent.
  - If an employee is court ordered to provide medical coverage for a dependent, including a spouse, Optima Health will allow the employee and the dependent to enroll in the plan if enrollment documentation is received within 30 days of the court order date. If the enrollment request is not received timely, the employee will not be able to add the dependent until the group's next Plan open enrollment period.
- **Medicare.** A covered person, who is eligible to be covered under Medicare (Title XVIII of the Social Security Act of 1965, as amended), is encouraged to enroll in Parts A and B coverage on the date they are eligible. If 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.

Business*EDGE*® (10–150 total employees) and Business*EDGE* elite™ (10–50 enrolling employees) Enrollment Guidelines

Policies/Procedures for Groups Applying for Coverage

Employer Contribution

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

Principal Ownership Companies

Principal ownership companies are eligible, given the following stipulations:

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

Group Waiting Periods

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

Participation Requirements

Groups are required to have 70% participation of eligible employees and no less than 10 enrolling employees. Employees who waive coverage to stay on another qualifying plan (such as Medicare, TRICARE/CHAMPUS, or a spouse's employer-sponsored plan) are not considered eligible employees for the purpose of the participation calculation, and will not count against the group's participation. To determine group participation:

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

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

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

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

Employee Enrollment Application

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

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

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

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

Waivers

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

- Self, which will include all dependents;
- Spouse only;
- Child or children only;
- Spouse and child or children; 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).

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

Virginia Employment Commission Quarterly Wage and Earnings Report

Along with the completed Employer Group Application and Individual Employee Application, groups applying for coverage must also supply a copy of the group's most recent Virginia Employment Commission (VEC) Quarterly Wage and Earnings Report.
The VEC report must clearly indicate the current status of each employee on the report as either:

- Full time (FT),
- Part time (PT) (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 should be signed and dated by an authorized representative of the group.**

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

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

Business*EDGE*® (10–150 total employees) and Business*EDGE* elite™ (10–50 enrolling employees) Enrollment Guidelines

Misstatement of Age or Class

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

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

Premium Check/Payments

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

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

Work-Related Illness and/or Injury

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

Stop-Loss Insurance

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

- Specific stop-loss protects employers if any member's eligible claims exceed a specific amount/deductible. The specified deductible is based on group size. The stop-loss insurance will pay for all eligible claims exceeding the specified deductible for the remainder of the contract year.
- Aggregate stop-loss provides additional protection if the total eligible claims, after excluding individual claim amounts above the specific stop-loss level, for all members exceed a defined amount/ aggregate attachment point. If the eligible claims are higher than this amount, then the stop-loss insurance will pay for all eligible claims exceeding this amount for the remainder of the contract year.

Stop-Loss Advancements

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

Run-out Period

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

The run-out period for the Business***EDGE*** or both Business***EDGE*** elite contracts will be 12 months after the end of each contract period. Any group surplus will be determined in the thirteenth month after the end of the contract year.

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

Member Claim Payment

Optima Health will be the claims fiduciary and will be responsible for all claim decisions.

Business*EDGE*® (10–150 total employees) and Business*EDGE* elite™ (10–50 enrolling employees) Enrollment Guidelines

Guidelines/Policies/Procedures

Business*EDGE* and Business*EDGE* elite New Business

Employer groups for Business***EDGE*** must have 15–100 total eligible employees with 10–150 enrolling employees. Employer groups for Business***EDGE*** elite must have between 10–50 total employees with 10–50 enrolling. The total employee count includes all full-time and part-time employees.

All enrollment forms should be completed and received by Optima Health 30 days prior to their requested effective date of coverage.

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

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

Initial Risk Assessment

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

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

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

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

Installation of Group

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

Business*EDGE*® (10–150 total employees) and Business*EDGE* elite™ (10–50 enrolling employees) Enrollment Guidelines

Enrollment Process

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

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

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

Items required to complete the enrollment process include:

- The most current version of the Application for Employer Stop-Loss Insurance
- Complete Employee Applications for every employee who is applying for coverage. All employees who are in their waiting period and are eligible for coverage within 90 days of the group's effective date should also complete an Employee Application. Applications must be signed and dated by applicant and plan administrator. NOTE: Any applications signed more than 90 days prior to the effective date will require a new, updated application. Any application submitted after the offer has been accepted could require the group to be re-underwritten, causing the group to be charged the appropriate premium as of the original effective date of the group.
- A complete group census form
- Waivers for eligible employees who are not electing coverage
- Prior carrier bill
- VEC, declaration letter, or other required eligibility documentation

Failure to Disclose

Benefits may not be payable for medical conditions that are not identified on an Employee Enrollment Application. Failure to disclose any medical condition / risk could result in denial of coverage as of the effective date or premium surcharge retroactive to the group's effective date.

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

Business*EDGE*® (10–150 total employees) and Business*EDGE* elite™ (10–50 enrolling employees) Enrollment Guidelines

Prior OHP or OHIC Group Coverage

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

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

Termination of Coverage

Sentara Health Plans, Inc. may terminate coverage for:

- Nonpayment of premiums, or
- Fraud or intentional misrepresentation of material fact under the terms of the coverage.

Additional Requirements/Information

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

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

Acceptance

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

- Employer Contract
- Employee Applications
- Waivers
- VEC

These documents need to be signed and dated by the employer and returned to Optima Health.

Membership Changes

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

- All changes must be submitted within 60 days of new-hire eligibility or a HIPAA Special Enrollment Provision (qualifying life event).

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

Retroactive Dis-Enrollment

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

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

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

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

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

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

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

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

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

Group Plan Changes

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

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

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

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

Monthly Payment Amounts

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

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

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

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

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

Business*EDGE*® (10–150 total employees) and Business*EDGE* elite™ (10–50 enrolling employees) Enrollment Guidelines

Rate Guarantee

All ***BusinessEDGE*** groups will be given a 12-month rate guarantee and Business***EDGE*** **elite** groups will be given an 18-month rate guarantee, and both will be composite rated. Adjustments for age will only occur on the Plan's anniversary date.

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

- Changes or more than 10% in the composition for covered employees;
- Any addition of a subsidiary, locality, a new startup company, or a new group class of employees coming onto its plan;
- The business is no longer in the same type of business/trade as when the plan was originally effective;
- Any changes made to the plan's benefits; and
- Any changes in the federal or state laws which could affect any covered employees. Optima Health has the right to make changes to the rates on any due date following the group's effective date of any state premium tax law, or change to such law. This change and amount will be determined by the amount imposed by the new tax law.

Renewal Proposals

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

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

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

Annual Open Enrollment Period

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

Mid-Market Group
Enrollment and Underwriting Guidelines

Employers, Employee, and Dependent Eligibility

Eligible Employers

- Corporations, partnerships, or sole proprietorships with a clear employer/employee relationship (1099 employee relationships are not eligible for group coverage)
- Employer groups not formed for the sole purpose of securing insurance
- Employer groups located within the Optima Health plan service area

Optima Health must be the only group healthcare coverage offered to all employees. Optima Health must be the only healthcare option offered to the local employees of a national company. In each of these cases, an employer participating in a contracted private exchange may be exempted.

Eligible Employees

An employee is eligible for coverage if he/she:

- Is employed by the group;
- Resides or works in the service area or is an out-of-area employee;
- Is working regularly at least 25 hours per week;
- Is at least 17 years of age;
- Within 31 days of the date of initial eligibility, files a complete enrollment application, including any applicable premium or fees, with the Plan;
- Does not knowingly give incorrect, incomplete, or deceptive information regarding his/her eligibility for coverage to the Plan or to the employer group;
- Does not knowingly give incorrect, incomplete, or deceptive information regarding his/her dependent's eligibility for coverage to the Plan or to the employer group;
- Meets any other requirements as specified herein, or as specified by the Plan or by the employer group; and
- Retirees, as long as the employer contribution is the same as full-time employees.

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

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

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

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

Out-of-Area Employees

Employees who reside and work outside of the service area, or spend more than 90 consecutive days for business purposes outside of the service area, can be included in the quote and will be offered an OOA PPO plans. It is recommended that no more than 20% of the covered employees can be covered under the OOA PPO.

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

Employees NOT Eligible

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

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

Eligible Dependents

- 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.

Out-of-Area Dependents

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

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

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

Dependents NOT Eligible

- Dependent children over age 26 EOM, unless incapable of self-support due to intellectual disability
- Any spouse or child who is insured as an employee of the same employer
- Grandchildren for whom the employee does not have legal custody
- Individuals no longer legally married to an eligible employee

Dependent Verification

OHP or OHIC may, at its discretion, require verification of dependent status from the group or insured employee (subscriber) at any time prior to or after coverage is effective. The following are the most common forms of verification:

- Birth certificate,
- Marriage certificate,
- Adoption certificate or proof of placement, 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 dis-enrolled from the Plan.

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

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

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

Member Plan Changes

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

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

- Eligibility after completion of new-hire waiting period,
- Loss of coverage under another plan,
- Reduction in hours,

- Reasons defined by Section 125 guidelines, 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 will provide special late-enrollment periods for eligible employees and dependents that fall into the following categories:

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

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

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

  Effective Date of Enrollment. Individuals must request coverage within 31 days of the marriage, birth, adoption, or placement for adoption. For special enrollment due to birth or adoption, late enrollment is effective on the date of the birth, adoption, or placement for adoption. For special enrollment due to marriage, late enrollment is effective no later than the first day of the calendar month beginning after the date a completed request for enrollment is received by the Plan.

- **Special enrollment for employees and/or dependents that lose eligibility under Medicaid or CHIP coverage.** Employees and/or dependents who are eligible for group coverage will be permitted to enroll late if they either lose eligibility for Medicaid or CHIP coverage, or become eligible to participate in a premium-assistance program under Medicaid or CHIP.

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

Effective Date of Coverage

Subject to the Plan's receipt of an enrollment application and any applicable premium, as determined in accordance with the Group's terms of proration, if any, from or on behalf of each prospective member, coverage shall become effective on the earliest of the following dates, unless otherwise specified by the group on the application.

- **Subscriber Coverage.**
  - When a person completes a written application for coverage on, or prior to, the date 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. The newborn child's coverage will be identical to coverage provided to the subscriber. If the newborn is not added to the Plan within 31 days of birth, the newborn may not be eligible to enroll until the next Plan open enrollment period.
- **Adopted or Foster Children.** An adopted or foster child will be eligible for coverage from the date of placement with an eligible subscriber for the purpose of adoption or foster care. An adopted child whose placement has occurred within 31 days of birth will be considered a newborn child of the subscriber as of the date of adoptive or parental placement. Evidence of placement and any applicable premiums must be submitted to the Plan within 31 days from the date of placement. If the adopted or foster child is not added to the Plan within 31 days of placement the child may not be eligible to enroll until the next Plan open enrollment period.
- **Coverage Mandated by Court Order.**
  - If an employer is court ordered by a Qualified Medical Child Support Order (QMCSO) to provide healthcare coverage for a dependent, and the employee does not currently carry healthcare coverage, the Plan will allow both the employee and court-ordered dependent to enroll within 31 days of the date of the court order (with proper documentation), provided the employee has met 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.** Employees whose employment status changes from part time to full time must meet the employer's eligibility waiting period before they can begin coverage.
  - If an employee is reinstated to a full-time status role within three months of moving to part-time, being laid off, and/or being terminated, 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

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

Principal Ownership Companies

Principal ownership companies are eligible, given the following stipulations:

- There must be a consistent principal owner in all companies (i.e. the same individual holds the largest stake in each company. A 50% stake in a 50/50 ownership is acceptable).
- Multiple-partner companies must provide documentation of partnership arrangements—as well as written documentation—signed by all partners, outlining parties eligible to authorize changes to the group's employee benefit package and broker arrangements.
- There must be a clear and demonstrable relationship to each of the sub-companies.
- All 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" Groups

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

Optima Health can administer different coverage for classes of employees. The determination of whether there is discrimination in benefits, premium contribution, and waiting periods will not be made by Optima Health. Employers must consult with their legal and tax advisors on this matter. Employers that discriminate in their healthcare plans may be subject to financial and tax penalties.

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

Waiting Periods/Contributions

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

Probationary/Orientation Periods

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

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

Participation Requirements

Groups with 51 or more total employees with less than 70% participation may be subject to a low participation load. Employees who waive coverage to stay on another qualifying plan (such as Medicare, TRICARE/CHAMPUS, or a spouse's employer-sponsored plan) are not considered eligible employees for the purpose of the participation calculation, and will not count against the group's participation. To determine group participation:

ABC Company	75	Total eligible employees (all full-time employees working 30+ hours weekly)
	-15	Employees enrolled on their spouses' or other plan (must have waiver)
=	60	Eligible employees to be counted toward participation requirement

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

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

Employer Group Health Questionnaire

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

- Name of employee (optional)
- Date of birth of employee (required)
- Gender of employee (required)
- Social Security number of employee and dependents (optional, required for enrollment)
- Level or tier of coverage (required) as follows:
  - Employee
  - Employee + 1 child
  - Employee + spouse

- Employee + children
- Family
- Waiver—other coverage
- Waiver—other

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

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

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

Waivers

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

- Self, which will include all dependents;
- Spouse only;
- Child or children only;
- Spouse and child or children; 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/Health Questionnaires or Employer Group Health Questionnaire, groups applying for coverage must also supply (may be required prior to submission for underwriting) a copy of the group's most recent Virginia Employment Commission (VEC) Quarterly Wage and Earnings Report.

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

- Full time (FT),
- Part time (PT) (must work at least 25+ hours weekly to be eligible),
- Not eligible (NE)—Please note class of ineligibility: 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/Health Questionnaire must be completed).

A letter signed by an authorized representative of the group is required to verify eligibility for any newly hired employees or owners not listed on the VEC report. In addition, changes/deletions made on the actual VEC report should be signed and dated by an authorized representative of the group.

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

- Declaration letter listing all current eligible employees and social security numbers;
- Copy of business license;
- Papers of incorporation, listing principals/officers of the company;
- Partnership agreement;
- W2 form (if applying for coverage at year end and prior to next quarterly VEC reporting, and/or employee is not considered a principal/owner of the company);
- 1040 Schedule C or F;
- IRS Schedule K1 (Form 1065 or 11205);
- IRS Form 1120; 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, gender, or level/tier of coverage of any insured employee has been misstated, the member's correct age, gender, or level/tier of coverage shall determine the amount payable under the group policy. All premiums due as a result of such misstatement will be adjusted and reflected on the group bill. Documentation may be required to validate corrections to previously stated information.

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

Premium Check/Payments

The initial employer enrollment check for the first month's premium (made payable to OHP or OHIC) will need to be submitted prior to enrollment. Groups should not submit their initial premium check until after underwriting and final rate determination has been made. All deposits and premium payments must be from the group in the form of a company check, money order, or cashier's check. If an initial binder payment is returned for non-sufficient funds (NSF) or any other reason, coverage may be terminated as of the original effective date.

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

Work-Related Illness and/or Injury

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

Guidelines/Policies/Procedures

Mid-Market Group New Business

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

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

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

Items required to complete the enrollment process include:

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

Risk Acceptance

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

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

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

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

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

OHP and OHIC may terminate coverage for:

- Nonpayment of premiums,
- Fraud or intentional misrepresentation of material fact under the terms of the coverage, or
- Violation of participation or contribution rules.

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

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

Additional Underwriting Requirements/Information

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

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

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

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

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

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 due to the under-contract requirement, in conjunction with the cancelation notification, the group will be issued a benefit renewal reflecting a maximum rate increase.

Groups that increase their eligible employees to the required minimum of two will be re-underwritten. If the additional application is received by the renewal deadline and new renewal rates may be established.

If the group's minimum participation is not increased prior to the group's 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/Health Questionnaire. Applications/Health Questionnaires must be complete and accurate. Applications to add newborns or adopted children must be received within 31 days from the date of birth or placement. Documentation must be provided to show the date of birth or adoption.
- The Application/Health Questionnaire must be signed by the applicant and submitted within 30 days of the requested effective date.
- Membership additions/changes that are submitted within 90 days of the group's initial effective or renewal date may require the group to be resubmitted to underwriting for re-evaluation and rate adjustment.
- In the event that enrollment changes increase or decrease the group's existing census by 15% or more, the group will be subject to underwriting review and may be re-rated for a new contract period using the most current rates available.

Retroactive Dis-enrollment

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

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

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

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

If a group submits a retroactive-termination request to Optima Health, the group must ensure that employees and dependents did not pay premiums/contributions during the retroactive-termination time period. When retroactive terminations are submitted, Optima Health will regard the

submission as verification that no premium/contribution was paid by the member/dependent for that period.

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

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

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

The group will maintain adequate records and provide any information required by Optima Health to verify that all ACA and all state Health Reform conditions for retroactive termination of coverage have been met. The Plan may examine the group's records relating to the coverage under this agreement during normal business hours at a location mutually agreeable to the group and the Plan.

Plan Changes

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

- Requests for proposal for off-cycle changes must be received by Optima Health, in writing from the company or the agent/broker, at least 75 days prior to the requested effective date.
- A final decision on any potential change–including exact plan designs to be offered and any required supporting documentation—must be received by Optima Health at least 65 days in advance of the proposed effective date. Please note that if day 65 falls on a weekend or holiday, Optima Health will need the decision by the last business day beforehand.
- Upon receipt of the final decision, the Optima Health Account Executive will forward via email the appropriate new Summary of Benefits and Coverage (SBC) document(s), for distribution by the group to its employees 60 days prior to the change effective date.
- Please allow no less than five business days for the completion of plan change requests.
- Any group making an off-cycle change will receive a new contract year/effective date using current quarter rates. All member deductible and maximum out-of-pocket accumulators will reset with the new effective date.
- If groups do not meet these timelines, they will have to wait until the following month to make their benefit change.

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

Premium Payments

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

Reinstatement of Groups Terminated for Non-Payment of Premium

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

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

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

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

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

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

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

Renewal Proposals

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

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

Large Group
Enrollment and Underwriting Guidelines

Employers, Employee, and Dependent Eligibility

Eligible Employers

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

Eligible Employees

An employee is eligible for coverage if he/she:

- Is employed by the group;
- Is at least 17 years of age;
- Is working regularly at least 25 hours per week, 50 weeks per year;
- Within 31 days of the effective date of coverage files a complete enrollment application, including any applicable premium or fees, with the Plan;
- Does not knowingly give incorrect, incomplete, or deceptive information regarding his/her eligibility for coverage to the Plan or to the employer group;
- Does not knowingly give incorrect, incomplete, or deceptive information regarding his/her dependent's eligibility for coverage to the Plan or to the employer group; and
- Meets any other requirements as specified by the Plan or by the employer group (such as early- and Medicare-eligible retirees or pensioned employee).

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

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

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

Out-of-Area Employees

Employees who reside outside of the service area, or spend more than 90 consecutive days for business purposes outside of the service area, can be included in the quote and will be offered an OOA PPO plan.

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

Employees NOT Eligible

- Independent contractors (1099) of the employer
- Part-time employees who work less than the minimum hours required by the Plan or the employer, or leased, temporary, or seasonal employees
- Directors, board members, and officers not otherwise eligible as active, full-time employees

Eligible Dependents

- The legal spouse of the insured employee
- Children up to the end of the month (EOM) or end of year (EOY) in which they turn age 26, depending on what is requested and underwritten. Eligible children include:
  - Natural or 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/EOY based on any of the following:

- Financial dependency on the subscriber or any other person,
- Residency with the subscriber or any other person,
- Student status,
- Employment status, 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/EOY does not extend to a spouse of a child receiving dependent coverage. Eligibility to age 26 EOM/EOY does not extend to a child of a child receiving dependent coverage unless grandchildren are eligible under the terms of the Plan or if the subscriber has legal custody of the grandchild.

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

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

Out-of-Area Dependents

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

HMO and POS Plans: Through the Out-of-Area Dependent Program, dependent **children** who **reside** outside of the Plan's service area can receive in-network benefits through the PHCS/Multiplan national network of providers. Pre-Authorization applies as necessary. The dependent child(ren) residing outside of the area must provide validation annually. Each eligible child will receive a special ID card with a PHCS/Mulitiplan logo on the front of the card, indicating participation in the program.

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

Out-of-Area Dependent Children Rider

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

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

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

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

Dependents NOT Eligible

- Dependent children over age 26 EOM/EOY, unless incapable of self-support due to intellectual disability (dependent age limits may be modified to cover children older than 26 EOM/EOY upon group request and underwriting approval at initial enrollment or prior to annual renewal)
- Any spouse or child who is insured as an employee of the same employer
- Grandchildren for whom the employee does not have legal custody
- Individuals no longer legally married to an eligible employee

Dependent Verification

OHP or OHIC may, at its discretion, require verification of dependent status from the Group or insured employee (subscriber) at any time prior to or after coverage is effective. The following are the most common forms of verification:

- Birth certificate,
- Marriage certificate,
- Adoption certificate or proof of placement, and
- Custody papers.

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

The Plan reserves the right to request or review at any time, at its sole and absolute discretion, proof of eligibility of any subscriber or dependent enrolled in the Plan. Should the Plan discover at any time that any subscriber or dependent is not eligible for coverage, was never eligible to be enrolled for coverage, and/or submitted false proof of eligibility for coverage, the Plan may, at its sole discretion, either refund all or part of the premium payment made on behalf of the subscriber/dependent to the group and retract all or part of any claims paid from the provider(s), or retain the premium paid on behalf of the ineligible subscriber/dependent up until the date the Plan became aware of the ineligibility and cancel the subscriber's/dependent's coverage after the date through which premiums were paid. Dis-enrollment of a subscriber or dependent due to ineligibility for coverage may result in the reversal and/or denial of claims during the period of ineligibility. The subscriber/dependent may be held responsible for any charges for claims for services during the period of ineligibility.

HIPAA Special Enrollment Provisions

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

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

  Effective Date of Enrollment. Individuals must request enrollment no more than 31 days from the time that the individual knew or should have known that the other coverage has been exhausted. Late enrollment is effective no later than the first day of the calendar month beginning after the date a completed request for enrollment is received by the Plan.
- **Late enrollees due to marriage, birth, adoption, or placement for adoption or foster care.** If a dependent is added through marriage, birth, adoption, or placement for adoption or foster care, the employee and all dependents are entitled to become covered through special late enrollment. Individuals in this category do not have to have declined coverage because they had other coverage.

  Effective Date of Enrollment. Individuals must request coverage within 31 days of the marriage, birth, adoption, or placement for adoption. For special enrollment due to birth or adoption, late enrollment is effective on the date of the birth, adoption, or placement for adoption. For special enrollment due to marriage, late enrollment is effective no later than the first day of the calendar month beginning after the date a completed request for enrollment is received by the Plan.

- **Special enrollment for employees and/or dependents that lose eligibility under Medicaid or CHIP coverage.** Employees and/or dependents who are eligible for group coverage will be permitted to enroll late if they either lose eligibility for Medicaid or CHIP coverage, or become eligible to participate in a premium-assistance program under Medicaid or CHIP.

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

Policies/Procedures for Groups Applying for Coverage

Employer Contribution to Premium

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

Employer Contribution to Deductible

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

Principal Ownership Companies

Principal ownership companies are eligible given the following stipulations:

- There must be a consistent principal owner in all companies (i.e. the same individual holds the largest stake in each company).
- Multiple-partner companies must provide documentation of partnership arrangements—as well as written documentation—signed by all partners outlining parties eligible to authorize changes to the group's employee benefit package and broker arrangements.
- There must be a clear and demonstrable relationship to each of the sub-companies.
- All of the employees will be used to determine rating and plan selection.
- In the event that the group wishes to divide the companies into separate group plans, each company will be separately evaluated to determine rating and plan coverage.

"Class" Groups

Optima Health can administer different coverage for classes of employees. The determination of whether there is discrimination in benefits, premium contribution, and waiting periods will not be made by Optima Health. Employers must consult with their legal and tax advisors on this matter. Employers that discriminate in their healthcare plans may be subject to financial and tax penalties.

Participation Requirements

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

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

Work-Related Illness and/or Injury

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

Group Acceptance

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

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

Size and Underwriting Limits

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

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

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

Request for Proposals

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

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

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

- Employer contribution amounts and/or percentages and waiting period for new hires;
- Top facilities and providers used during the experience period; and
- Requested commission level.

Quote and Proposal Criteria

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

Premium Check/Payments

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

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

Continuation of Coverage

Continuation of Coverage during Absence from Employment

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

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

Consolidated Omnibus Budget Reconciliation Act of 1985

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

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

Medical Loss Ratio Rebate Distribution

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

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

Broker
Policies and Procedures

Agent/Broker Appointment Policy

Appointment Policy Statement

OHP and OHIC require that all agents/brokers and agencies be appointed before the release of any marketing materials, proposal quotes, or information regarding new and existing business. Appointments with OHP and OHIC are not guaranteed. All requests are subject to review and approval of designated OHP and OHIC management.

Appointment Procedure

To gain an appointment, the agent/broker and agency (if commissions are to be paid to an agency) must have a valid Life and Health license from the Commonwealth of Virginia. Appointments are done online at optimahealth.com. The following need to be submitted to obtain appointment:

- A copy of the Life and Health license or Certifying Letter for the agent/broker,
- A copy of the Life and Health license for the agency or Certifying Letter (if commissions are to be paid to an agency),
- An executed Broker Agreement,
- A completed Substitute Form W-9, and
- Appointment fee.

NOTE: OHP and OHIC require that all agent/brokers and agencies obtain appointment to both companies.

Broker Training

All newly appointed brokers may be required to attend a Product Training class. Failure to attend product training could result in the cancellation of the appointment with OHP and OHIC.

Points to Remember

- If an agent/broker assigns payment of commissions to an agency, both the agent/broker and agency must be appointed.
- Optima Health will pay the annual state fee for renewing appointments provided an agent/broker or agency has active business. If an agent/broker or agency fails to maintain active business for a period of 12 months, the appointment may be terminated.
- OHP and OHIC reserve the right to amend the Plan's requirements for obtaining and maintaining appointment at any time.

This policy ensures our compliance with the State Corporation Commission BOI regulations and laws as outlined in the *Bureau of Insurance Administrative Letter 2002–1.*

Commissions Policy and Schedule

Agents/brokers must be appointed to Optima Health before they can represent our products and receive compensation. Please visit optimahealth.com/brokers to view our broker compensation program. Online registration is required.

Agent of Record (AOR)/Broker of Record (BOR) Change Letter

AOR/BOR changes received by the fifteenth of the month will take effect on the first of the following month. AOR/BOR changes received after the fifteenth of the month will take effect on the first day of the second following month.

- Examples:
  - New agent submits an AOR/BOR on May 13. The AOR/BOR change is effective June 1 unless it is rescinded.
  - New agent submits an AOR/BOR on May 19. The AOR/BOR change is effective July 1 unless it is rescinded.

AOR/BOR changes are also subject to the following guidelines:

- The request to change the AOR/BOR must be on either company letterhead or on the Optima Health AOR/BOR change document and signed by an officer of the company or the BA as designated on the group's original Employer Group Application, or written change to the BA, received during the group's history.
- The new agent/broker must be appointed with OHP and OHIC, and be in good standing with the Virginia BOI.
- The new agent/broker, the current agent/broker, and the group contact will all be notified as to the receipt of the letter and the date that the change will take effect.
- Group information will be released to the new agent/broker after verification and approval is received from the group contact.
- Commissions payable on any premiums billed and due for periods prior to the effective date of the new AOR/BOR change will be payable to the previous agent/broker. Commissions will be paid to the new agent/broker beginning with the month's premiums billed and due on or after the effective date of the agent of record change. The new agent/broker will NOT receive commissions on premiums due for billing periods prior to the AOR/BOR change.
- The current agent/broker can have the AOR/BOR change rescinded before the effective date of change by providing a letter from the group requesting that the change be canceled.

Proposal Preparation for Brokers

Proposal Preparation Policy Statement

OHP and OHIC will provide proposals to its appointed brokers who show proof that the employer with whom they are working wishes to obtain a quote. Proof can be in the form of an AOR letter, census information, submission of Optima Health Employee Application/Health Questionnaires, or a Large Group Employer Group Health Questionnaire.

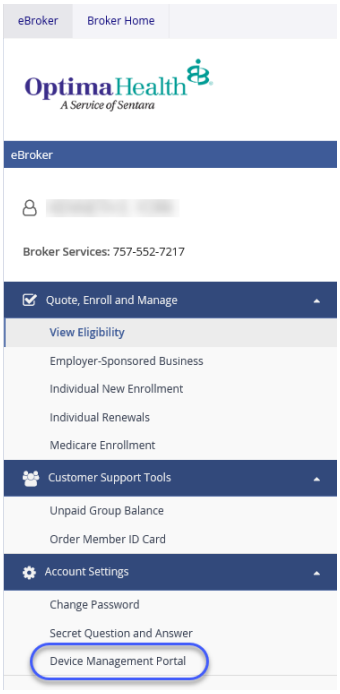
Points to Remember

OHP and OHIC will release quotes to multiple brokers until such time as the group makes a final determination on broker designation. Final determination will be based on whichever broker submits the group's initial premium check (small group only) and final enrollment information, or when written documentation is received from an authorized representative of the group. In the event that multiple brokers have obtained quotes on a group, a representative from OHP or OHIC will contact the group's BA/owner prior to enrollment in order to verify the final agent/broker designation. Proposals generated to each broker will be based on information provided by that broker only. Quotes may vary accordingly.

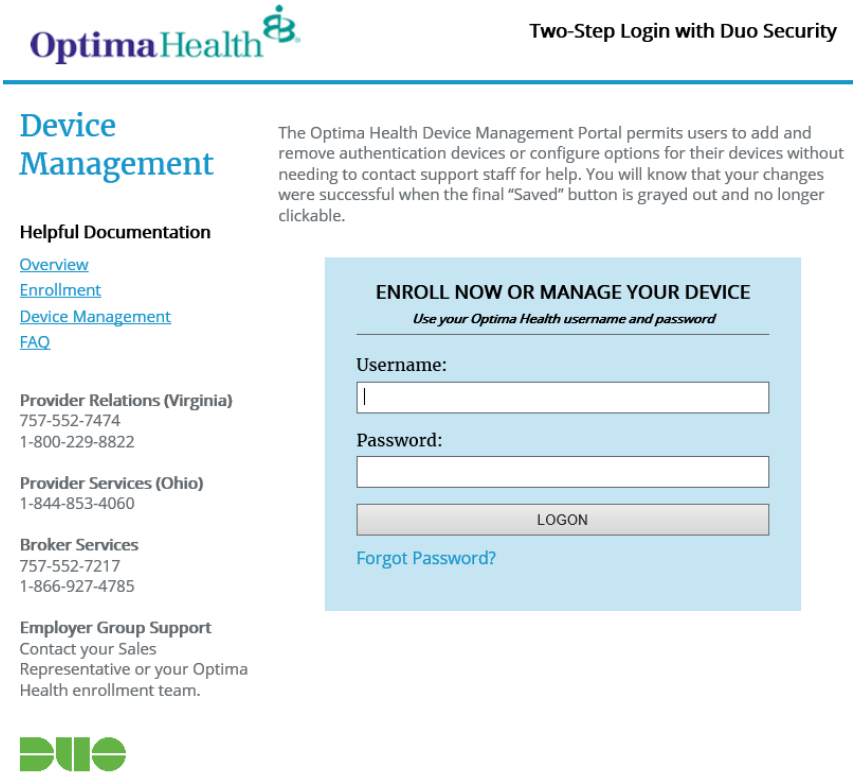
Online Broker Portal

From the broker portal, you can easily manage new and existing clients at any time of the day. After you register on optimahealth.com, if you sign in to optimahealth.com to access the secure features, you must complete a two-step login process. To set up your computer, phone, and other devices:

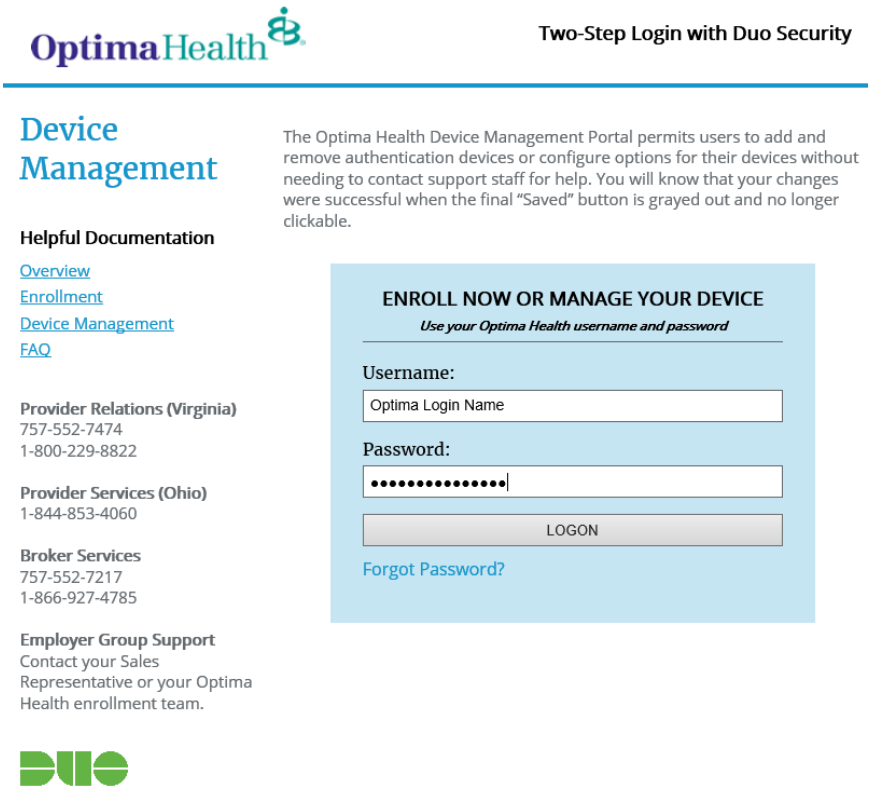
- Sign into Optimahealth.com Broker portal, select “Device Management Portal”:



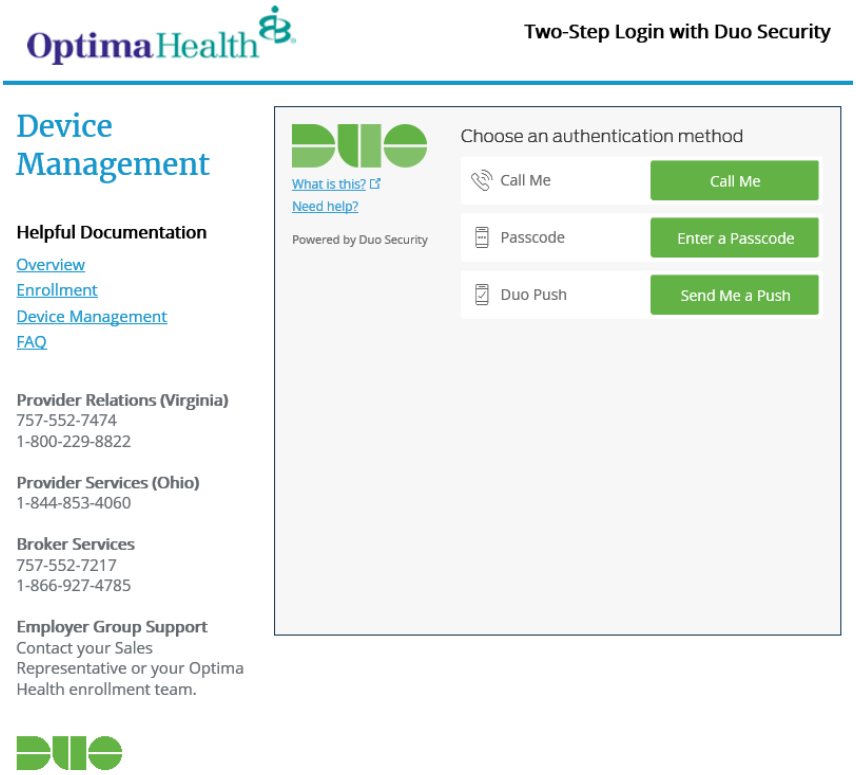
- You should see this screen:



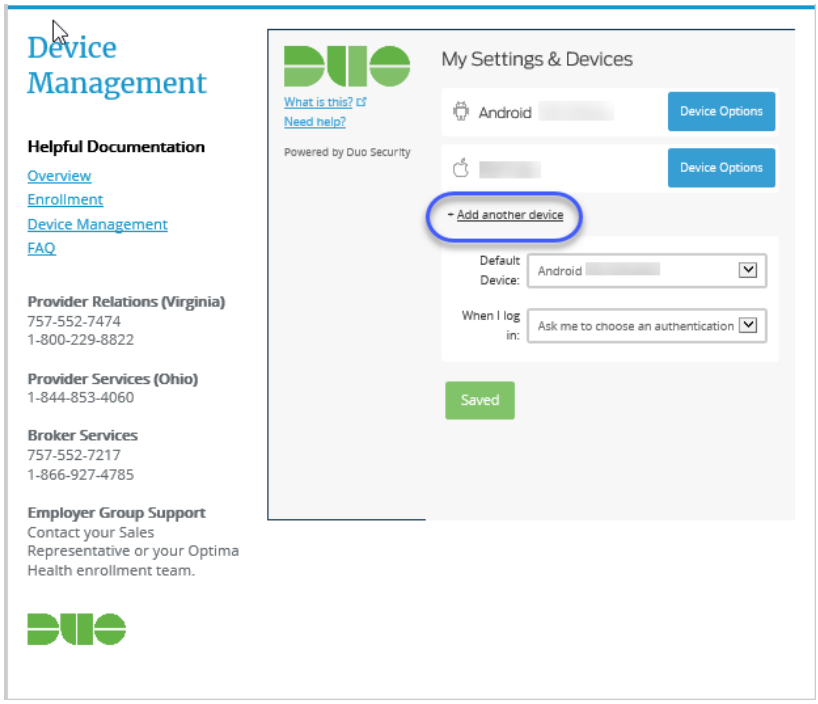
- Sign in using your optimahealth.com username and password:



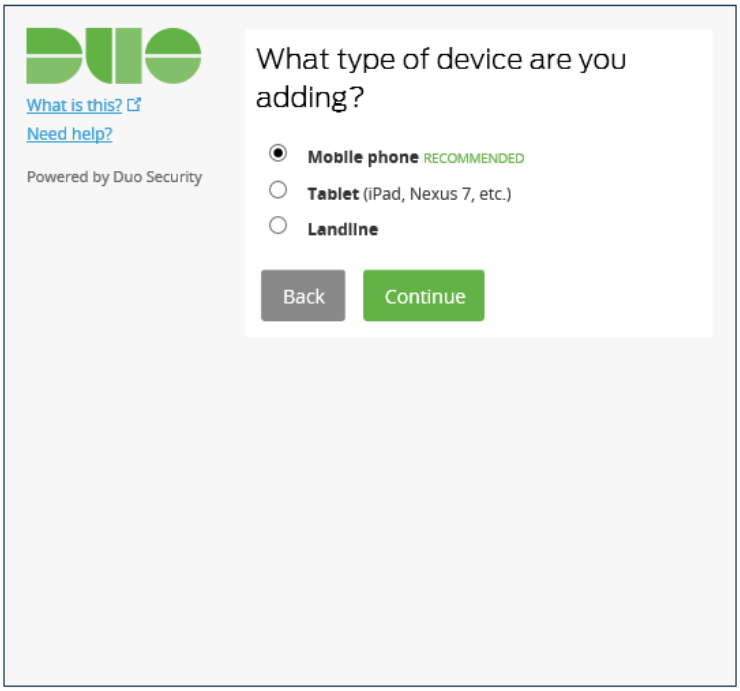
- Select your authentication method:



- Once authenticated you will see this screen:



- If you select “Add Another Device,” you can add a second mobile phone or a landline. Adding other devices allows you select a default device.



After you have signed up the devices you wish to use, when you sign in to optimahealth.com, you will be prompted to authenticate your device. You will only need to authenticate your device once every 24 hours.

Substitute Form W-9
(SF-W9)

Optima Health Plan Substitute Form W-9 (SF-W9)

Optima Health Plan
Optima Health Insurance Company
4417 Corporation Lane
Virginia Beach, VA 23462

SUBSTITUTE FORM W-9 (SF-W9)

Please complete the information on the form provided. We are required by the Internal Revenue Service (IRS) to obtain this information when making reportable payments to you. If we do not obtain this information, our payments to you may be subject to a 31-percent federal income tax backup withholding, and you could be subject to a $50 penalty by Internal Revenue Code Section 6723. Backup withholding is not a failure to pay you. It is an advance to the IRS on your behalf.

Below are the different types of tax statuses. Please complete the appropriate information based on your tax status.

If your tax status, business name, or tax identification number has changed during the tax year, please provide us with both sets of information and the date of the change.

Taxpayer	Business Name	Taxpayer Name	Taxpayer ID Number
Individual	Individual's Name	Same	SSN
Sole Proprietor	Payee/DBA Name	Owner's Name	SSN or Federal ID #
Corporation	Payee/DBA Name	Name on Federal ID #	Federal ID #

Please return this form within 10 days by mail or by fax to 757-837-4881.

If you have any questions about this form, call 757-552-7217, or toll-free at 1-866-927-4785.

Optima Health Plan Substitute Form W-9 (SF-W9)

If commissions will be paid to an **agency** please fill out **Section A** using the agency's tax information and have the agent fill out **Section B**.
If commissions will be paid to an **individual** please fill out **Section A** using the agent's social security # and do not fill out **Section B**.

Section A: Please check the appropriate category to which commissions will be assigned and paid.

Office Use Only: V# _____

Check Only One:

_____ Individual	Social Security #	_____
_____ Sole Proprietor	Federal ID #	_____
_____ Corporation	Federal ID #	_____
_____ Other	Federal ID #	_____

Enter the following information in accordance with the TAX ID # used above:

Legal Name: _____
(Must match name on your federal return)
Trade Name: _____
(if applicable)
Mailing Address: _____
_____

Mailing Address: _____
(for commission checks, if different)
_____

Agent Telephone #: _____ **Agent Fax #:** _____
Agent Pager #: _____ **Agent Cell #:** _____ **Agent Email:** _____

Please answer the following questions:

1. Is this organization tax exempt under IRS Code Section 501(a)? YES NO
2. Is this a Minority-Owned, Woman-Owned and/or Small Business? YES NO

Certification: Under penalties of perjury, I certify that:
The taxpayer identification name and number shown on this form is correct and I have _____/have not_____ been notified by the IRS that I am subject to backup withholding. If yes, date of notification _____.

Signature _____ Date _____

Section B: Please complete the following information if agent is assigning commissions to be paid directly to the agency listed in Section A.

PLEASE READ: All rights and responsibilities are assigned to the agency named above. In the event that the relationship between the above named agency and the undersigned agent is dissolved, all responsibility for servicing accounts and all commissions will remain with the agency unless the group submits an agent of record change.

Agent's Printed Name _____ Agent's Signature _____

Agent's Social Security Number _____ Date _____

VA BOI Administrative Letters and Site Map

Administrative Letters that should be reviewed by every agent

There are a number of administrative letters that should be carefully reviewed by any person licensed as an insurance agent in Virginia. Specifically, licensees should review, at a minimum, the following (found online at http://www.scc.virginia.gov/boi/adminlets/allagents.aspx):

Letter - Subject	Life and Annuities	Health	Property & Casualty	Title
2001-9 - SCC Advises Agents to Beware when Selling Health Insurance Coverage	X	X		
2002-1 - Procedures To Recognize Military Call-Up To Active Duty - Agent Licensing and Agent Appointment Processes	X	X	X	X
2002-8 - Changes in Laws Governing Licensing of Various Types of Insurance Agents And Procedures	X	X	X	X
2002-8 - License Conversion Table of Virginia License Types	X	X	X	X
2002-9 - Insurance Activities Requiring Persons To Be Licensed	X	X	X	X
2003-4 - Senate Bill No. 878 Privacy Safeguards	X	X	X	X
2004-3 - Procedural changes, administrative changes and clarifications regarding agent licensing and the Bureau's Agent Licensing Section	X	X	X	X
2004-5 - Legislation Enacted by the 2004 Virginia General Assembly	X	X	X	X
2005-9 - Implementation of electronic non-resident licensing (eNRL) with electronic funds transfer for licensing fees	X	X	X	X
2006-1 - Implementation of Procedure Change in Requesting Letters of Certification	X	X	X	X
2006-4 - Implementation of Procedure Change in Requesting a Duplicate License	X	X	X	X
2006-7 - Online Address Changes	X	X	X	X
2006-11 - Procedural change: Displaying National Producer Numbers (NPN) in Lieu of Social Security/DMV-Assigned Numbers	X	X	X	X
2007-1 - Flood Insurance Training Requirements for Insurance Agents with a Property and Casualty License or Personal Lines License Selling through the National Flood Insurance Program (NFIP)			X	
2007-3 - Chapter 200 of Title 14 of the Virginia Administrative Code Rules Governing Long-Term Care Insurance Long-Term Care Partnership Program	X	X		
2007-4 - Change in Vendor Providing Insurance License Examinations	X	X	X	X
2007-5 - Administrative Changes and Changes in Laws Governing Agent Licensing	X	X	X	X
2008-3 - Rules Governing Military Sales Practices (14 VAC 5-420-10 et. seq.)	X	X		
2008-8 - Legislation Enacted by the 2008 Virginia General Assembly	X	X	X	X

2008-11 - Implementation of the New Bureau of Insurance Sircon for States System	X	X	X	X
2009-05 - Legislation Enacted by the 2009 Virginia General Assembly	X	X	X	X
2010-02 - Online Printing of Producer Licenses	X	X	X	X
2010-06 - Legislation Enacted by the 2010 Virginia General Assembly	X	X	X	X
2011-02 - Notice Concerning Certificates of Insurance			X	
2011-04 - Legislation Enacted by the 2011 Virginia General Assembly	X	X	X	X
2012-04 - Revised Gramm-Leach-Bliley Act Privacy Notices; Withdrawal of Administrative Letter 2011-06	X		X	
2012-05 - Legislation Enacted by the 2012 Virginia General Assembly	X	X	X	X
2013-02 - Revisions to the Virginia Insurance Continuing Education Program Requirements, effective January 1, 2013	X	X	X	X
2013-05 - Legislation Enacted by the 2013 Virginia General Assembly	X	X	X	X
2014-04 – Legislation Enacted by the 2014 Virginia General Assembly	X	X	X	X
2015-07 – Requirements for Adverse Underwriting Decisions and Notices; Withdrawal of Administrative Letters 1978-4; 1978-9; 1978-11; 1981-4; 1981-15, 1981-16, and 2003-06	X	X	X	
2015-10 - Insurance-Related Legislation Enacted by the 2015 Virginia General Assembly	X	X	X	X
2016-04 - Insurance-Related Legislation Enacted by the 2016 Virginia General Assembly	X	X	X	X
2017-02 - Insurance-Related Legislation Enacted by the 2017 Virginia General Assembly	X	X	X	X

Last Updated: November 19, 2018

To view The Commonwealth of Virginia State Corporation Commission website site map, visit

http://www.scc.virginia.gov/boi/adminlets/allagents.aspx

Terms/Acronyms

Terms and Acronyms Used in this Guide

ACA	Affordable Care Act
AOR	Agent of Record
AWP	Average Wholesale Price
BA	Benefits Administrator
BOI	Bureau of Insurance
BOR	Broker of Record
CABG	Coronary Artery Bypass Graft
CDHP	Consumer-Directed Health Plan
CHIP	Children's Health Insurance Plan
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
EFT	Electronic Funds Transfer
EOM	End of Month
EOY	End of Year
ESRD	End-Stage Renal Disease
FT	Full Time
HSA	Health Savings Account
HIPAA	Health Information Portable Care Act of 1996
HMO	Health Maintenance Organization
HRA	Health Reimbursement Account
IRS	Internal Revenue Service
MLR	Medical Loss Ratio
NE	Not Eligible
NSF	Non-sufficient Funds
OHIC	Optima Health Insurance Company (PPO products)
OHP	Optima Health Plan (HMO, POS, and POSA products)
OOA	Out of Area
PCPM	Per Contract Per Month
POS	Point of Sale
PPO	Preferred Provider Organization
PT	Part Time
QMCSO	Qualified Medical Child Support Order
SBC	Summary of Benefits and Coverage
T	Terminated
VEC	Virginia Employment Commission
W	Waving Coverage

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

www.optimahealth.com