



BENEFIT ADMINISTRATOR GUIDE

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This guide serves as a convenient reference on general administrative topics such as Eligibility, Enrollment, Membership Changes, Primary Care Physician Changes, Continuing Coverage, and Group Billing. Specific questions regarding Group Billing, Eligibility, and Enrollment documents should be directed to the Account Services Department. The Account Services Department is available Monday through Friday, 8:00 a.m. to 5:00 p.m. and may be reached by dialing (757) 687-6400 or toll-free 1-866-472-5764.

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

This Guide is for general administrative purposes only. It is not a contract or policy. The Evidence of Coverage or Certificate of Insurance, the Plan's legal documents, will prevail for all benefits, conditions, limitations, and exclusions. Thank you for choosing Optima Health Plan.

We look forward to serving you and your employees in the months and years to come.

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Optima Health is the trade name of Optima Health Plan, Optima Health Insurance Company, Optima Health Group, Inc., and Sentara Health Plans, Inc. Optima HMO products, and Point of-Service products are underwritten by Optima Health Plan. Optima Preferred Provider Organization products are underwritten by Optima Health Insurance Company. Self-funded plans are administered by Sentara Health Plans, Inc.

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Employee and Dependent Eligibility

Eligible Employees

An employee is eligible for coverage if he/she:

1. is employed by the group; and
2. resides or works in the service area or is an out-of-area employee (and no more than 50 percent of the eligible and enrolled employees are out-of-area with no more than 10 percent Out-of-State); and
3. is actively at work; and
4. is working regularly at least 25 hours per week, 50 weeks per year; and
5. is at least 17 years of age; and
6. within 31 days of the effective date of coverage files a complete enrollment application, including any applicable premium or fees, with the Plan ; and
7. does not knowingly give incorrect, incomplete, or deceptive information regarding his/her eligibility for coverage to the Plan or to the Employer Group; and
8. does not knowingly give incorrect, incomplete, or deceptive information regarding his/her dependent's eligibility for coverage to the Plan or to the Employer Group; and
9. meets any other requirements as specified herein, or as specified by the Plan or by the Employer Group.

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 Optima Health Plan (OHP) or Optima Health Insurance Company (OHIC), but only if they do so for all of the employees. After initial enrollment, **the new-hire waiting period can only be changed at renewal.**

Employees NOT Eligible

- Employees who engage in foreign travel exceeding 90 consecutive days.
- Independent contractors (1099) of the employer.
- Part-time (employees who work less than the minimum hours required by the Plan or the employer), leased, temporary, or seasonal employees.
- Directors and officers not otherwise eligible as active, full-time employees are not eligible simply because of their status.
- Retirees or pensioned employees.
- A person who would otherwise be eligible for coverage may nonetheless be ineligible if that person 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.

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 (foreign travel excluded), can be included in the quote and will be offered one of the Out-of-Area PPO (OOA PPO) plans. No more than 50 percent of the eligible employees can reside out of the Optima Health service area (within Virginia) and no more than 10 percent may reside out of the Optima Health service area (outside of Virginia). If the employer group exceeds either of these Out-of-Area percentages, and an exception is not approved, 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, which provide access to in network providers, are the Optima Health Insurance Company PPO network and a contracted national PPO network. Members accessing 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.

Eligible Dependents

- The legal spouse of the insured employee.
- The insured employee's unmarried children under 19 years of age who are dependent upon the employee and who are natural children, legally adopted children, or children under the legal custody of the insured. Stepchildren, whether residing with the member or not, are also eligible. Foster children are not eligible. Grandchildren are only eligible with proof of legal guardianship. (Coverage terminates at the end of the month in which the child turns 19 years of age.)
- The insured employee's unmarried children (as defined above) who are enrolled full-time (undergraduates with 12 or more credit hours per semester or otherwise considered full-time by the Institution; graduate students with six or more credit hours per semester) in an accredited educational institution, who are not employed anywhere on a full-time basis, and who are dependent upon the insured employee. (Coverage terminates at the end of the month in which the child turns 24 years of age or is no longer a full-time student, whichever comes first.)
- Continuation of coverage for full-time students - When the Plan provides coverage for a dependent child enrolled as a full-time student and that child is unable, due to a medical condition, to continue as a full-time student, coverage under the policy for that child will continue in force (i) for a period of 12 months from the date the child ceases to be a full-time student or (ii) until such child reaches the Plan's limiting age, as stated on the Plan's Face Sheet or Schedule of Benefits, for full-time students, whichever first occurs, provided the child's treating physician certifies to the Plan at the time the child withdraws as a full-time student that the child's absence is medically necessary. A child's status as a full-time student shall be determined in accordance with the criteria specified by the institution in which the child is enrolled.
- Unmarried dependent children (as defined above) over age 19 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

- Any spouse or child in the military service or government service of any country
- Married children
- Dependent children age 19 and over who are not enrolled as full-time students
- Dependent children age 24 and over regardless of student status
- Any spouse or child who is insured as an employee of the same employer
- Grandchildren for which the employee does not have legal custody
- Foster children
- Individuals no longer legally married to an eligible employee
- Domestic partners

Out-of-Area (OOA) Dependent Children

Employers with employees who are requesting coverage for eligible dependent children who reside outside of the Optima Health Plan (OHP) or Optima Health Insurance Company (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 the 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 entire group's premium on all plans purchased, not just on the plan chosen by the member(s) who currently enroll OOA children. The rider will remain as a benefit of the group, until written notification is received by the group benefit representative to request removal of the rider. The removal of the rider will be contingent upon the next effective date in which retroactive adjustment to the billing would be avoided.

Groups electing this rider must have employees with Out-of-Area dependents complete an Out-of-Area Dependent Notification Form annually for each covered Out-of-Area dependent.

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

Dependent Verification

Optima Health Plan or Optima Health Insurance Company may, at its discretion, require verification of dependent status from the group or insured employee 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
- Custody papers

Beginning September 1st, 2009, dependents enrolling in an Optima Health plan with a last name different from the last name of the subscriber will receive a letter requesting supporting documentation, as listed above. Members will have 45 days to provide this documentation or they may be disenrolled from the Plan. This 45 day timeline will not apply to members prior to September 1, 2009.

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

1. 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; or
2. Refund the premium payment made on behalf of the subscriber/dependent during the period of ineligibility to the group, disenroll the subscriber/dependent, and retract all or part of any claims paid from the provider(s) during the period of ineligibility. Disenrollment of a subscriber or dependent due to ineligibility for coverage may result in the reversal and/or denial of claims during the period of ineligibility. The subscriber/dependent may be held responsible by the provider(s) for any charges for claims for services received during the period of ineligibility; or
3. Refund the premium payment made on behalf of the subscriber/dependent during the period of ineligibility to the group, and disenroll the subscriber and/or dependent. The subscriber/dependent will be held responsible for any charges for claims for services received during the period they were not eligible to receive services. The Plan may seek to recover from the member Usual and Customary Charges for any claims paid by the Plan for services received during the period of ineligibility.

Member Plan Changes

Members may only enroll for benefits or change benefit plans once per year during the group's established open enrollment period. 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 criteria:

- Eligibility after completion of new-hire waiting period; or
- Loss of coverage under another plan; or
- Reduction in hours; or
- Reasons defined by Section 125 guidelines; or
- HIPAA "Special Enrollment Provisions".

Pre-Existing Condition Guidelines

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

The pre-existing condition waiting period does not apply to:

1. A newborn, adopted child under age 18, or a child under age 18 placed for adoption as long as the child became covered under health coverage within 30 days of the birth, adoption, or placement for adoption and provided that the child does not incur a subsequent 63-day break in coverage; or
2. Pregnancy; or
3. Genetic information; or
4. Covered services for breast cancer when the member has been breast cancer free for at least five years.

Pre-existing condition guidelines are applied to members of groups which:

- Have 2-14 eligible employees and offer **any** Optima Health plans; or
- Have 15+ eligible employees, offer Optima Health PPO plans, and do not have group coverage in force prior to enrolling with Optima Health.

Creditable Coverage

For members enrolling in groups subject to pre-existing condition guidelines, the pre-existing condition period may be reduced by any periods of creditable coverage, provided there has been no break in coverage exceeding 63 consecutive days. Employer-imposed waiting periods do not count as lapses in coverage. Coverage considered creditable includes:

2. Group health plans, including COBRA continuation coverage;
3. Health insurance coverage (care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurer);
4. Individual coverage;
5. Medicare Part A or B;
6. Medicaid;
7. Military service related care such as CHAMPUS;
8. A medical care program of the Indian Health Service or of a tribal organization;
9. A state health benefits risk pool;
10. A health program offered under the Federal Employees Health Benefits Program;
11. A public health plan – any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the Plan;
12. A health plan offered under the Peace Corps Act; and
13. A State Children's Health Insurance Program under Title XXI of the Social Security Act.

Proof of Prior Coverage

At the time of enrollment, members with creditable prior coverage must submit proof of this coverage with their enrollment application. The following are examples of acceptable documentation:

- Letter or Certificate of Creditable Coverage from the previous insurance company.
- Letter or Certificate of Creditable Coverage from the current or previous employer(s).
- Defense Enrollment/Eligibility Records (DEERS) and a copy of the front and back of military identification card.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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

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

Following is a sample certificate.

Certification of Group Health Plan Coverage

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

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

Statement of HIPAA Portability Rights

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

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

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

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

- Therefore, once your coverage ends, you should try to obtain alternative coverage as soon

as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any Pre-existing condition exclusion if you enroll in another plan.

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

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

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

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

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

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

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

HIPAA Special Enrollment Provisions

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

1. **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:
 - a. The employee and/or dependent must be eligible under the Plan's terms; and
 - b. 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
 - c. When the employee declined enrollment for the employee or dependent, either the employee 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.

2. **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.

3. **Special enrollment for employees and dependents that lose eligibility under Medicaid or CHIP coverage.** 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) 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, 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;

A. Subscriber Coverage.

1. When a person makes 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.
2. When a person makes 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.

B. 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.

C. 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. Lifetime maximums and limitations are based on each person's lifetime, regardless of the number of policies under which the person is or has been covered.

D. 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: (a) the date the subscriber's coverage becomes effective; or (b) 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.

E. Newborn Children. A newborn child will be covered from the moment of birth if the subscriber's coverage under this Plan is in effect, and if the subscriber adds the newborn to his or her coverage within 31 days of birth. An adopted child whose placement has occurred within thirty-one 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. It also will provide coverage for necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Inpatient and outpatient dental, oral surgical, and orthodontic services which are medically necessary for the treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia will be covered. 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.

F. Adopted Children. An adopted child will be eligible for coverage from the date of placement with an eligible subscriber for the purpose of adoption. A child whose placement has occurred within thirty-one 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 child is not added to the Plan within 31 days of placement the child may not be eligible to enroll until the next open enrollment period.

G. Coverage Mandated by Court Order. Coverage mandated by court order issues, including Qualified Medical Child Support Orders (QMCSOs), will begin on the date of the court order if the request is made and an enrollment application is submitted within 31 days of the order.

Coverage mandated by the Child Support Act will begin on the first of the month of the group's notification to the Plan. Subject to the eligibility requirements of the Plan and/or the group in order to provide coverage to a dependent child, both the child and the parent ordered to provide support may be required to enroll in the Plan.

- H. 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 you are under age 65, entitled to Medicare because of End Stage Renal Disease (ESRD), and have employer group health coverage, please contact the Plan regarding your participation with Medicare Part B or assistance in obtaining Part B.
- I. 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, unless otherwise agreed to by the Plan, and provided any new hire eligibility waiting period has expired.

Underwriting Guidelines/Policies/Procedures

Under Contract Groups

Under no circumstances can the size of the group fall below two (2) enrolled employees. A group that has only one contract may have 90 days, or until the group's renewal date (whichever comes first) to achieve two contracts or they will be cancelled.

If the group is receiving a cancellation notice due to the under contract requirement, in conjunction with the cancellation 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 (2) 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 1st of any month throughout the contract year (not retrospectively). Any changes will be subject to the following guidelines:

1. All changes must be submitted within 30 days of new-hire eligibility or a HIPAA "Special Enrollment Provision" (Qualifying Life Event).
2. 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. Newly enrolled members may be subject to a 12-month pre-existing condition limitation. Pre-existing condition limitations may be reduced by any periods of creditable coverage.
3. 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.
4. The Application/Health Questionnaire must be signed by the applicant and submitted within 30 days of the requested effective date.
5. 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 reevaluation and rate adjustment.

Retroactive Disenrollment

The group shall maintain adequate records and provide any information required by the Plan to administer their agreement. The Plan may examine the group's records relating to the coverage under their agreement during normal business hours at a location mutually agreeable to the group and the Plan.

The group shall notify the Plan in writing on a monthly basis on or before the 15th of each month of any member who has become ineligible for continued coverage under the Plan for any reason.

Upon such notification, the Plan may refund to the group up to the last sixty days of premium payments made by the group on behalf of the ineligible member.

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

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

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

As stated in the example, in no event will the Plan refund to a group any premium payments associated with members who have incurred claims during the period of ineligibility. Also, in no event shall the group withhold from premium payments due to the Plan any amount of premium payments made by the group on behalf of an ineligible member. The group agrees that should it be necessary that the Plan initiate legal action against the group to enforce the provisions of this, the group shall be liable to the Plan for all costs associated with the enforcement including but not limited to attorney fees, as well as any and all amounts due and owing under this Section 6.3.

The subscriber may be required to indemnify the Plan for the reasonable value of any service and benefits the Plan may provide, or that the Plan becomes legally obligated to provide by reason of the group's failure to notify the Plan of the member's ineligibility for continued coverage.

Plan Changes

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

1. The request must be received in writing from the company or the agent/broker.
2. Benefit changes requested outside of the group's anniversary (renewal cycle) will be submitted to underwriting for review.
3. Please allow no less than five (5) business days for the completion of underwriting for plan change requests.
4. Plan changes for an effective date in the four months prior to the group's anniversary (renewal cycle) will be looked at as an early renewal and will be underwritten with that quarter's rates and a new 12-month contract will ensue.

If, after the underwriting review, it is determined that the plan change reflects a DECREASE in benefit value, the group will NOT be re-underwritten. New benefits (and rates reflecting the benefit decrease) will go into effect on the next full or "clean" billing cycle and will run for the remainder of the group's contract term.

If, after the underwriting review, it is determined that the plan change reflects an INCREASE in benefit value, the group will be re-underwritten. If the benefit increase is approved, new rates will be issued and a new 12-month contract will ensue.

REMINDER: Effective dates for benefit changes requested off anniversary date will be determined by Optima Health, and will be contingent upon the next effective date in which retroactive adjustments to the billing would be avoided. 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 cancelled 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 1st 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 2nd – 15th days 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 time lines 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.

Optima Health Plan and Optima Health Insurance Company 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 group terminations have been 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 required to pay all past due and current premiums within 15 days of the date of termination and elect auto-debit of 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.

Continuation of Coverage

Continuation of Coverage During Absence From Employment

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

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

COBRA

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

- Employers with less than 20 employees
- Federal Government and the District of Columbia
- Church plans

Optima Health Plan/Optima Health Insurance Company (The Plan) agrees to provide continued healthcare services which will enable the group to comply with the requirements of COBRA, including the changes made under the Health Insurance Portability and Accountability Act of 1996 signed into law August 21, 1996, but disclaims any responsibility, implied or expressed, for such compliance.

Once a member becomes ineligible for coverage under the group plan, his/her coverage should be terminated effective the end of the month in which eligibility ceased. In addition, written notification must be received by the Plan when the member becomes ineligible.

Members electing COBRA must adhere to the following guidelines to receive continuation of coverage.

- Provide notification of the COBRA election to the group within 60 days of the qualifying event.
- Payment of the first premium must be received by the group within 45 days from the date of the COBRA election. Subsequent payments should be received within 31 days of the due date.
- COBRA participants must remain current with premium payments. In the event the member does not make premium payment to the group within 31 days of the date due, the member's coverage should be terminated and the Plan notified.

Note: Non-payment of premium by the member to the employer group does not negate the employer group's obligation to pay the Plan for health insurance coverage provided by the Plan on the member's behalf.

When the group receives notification of the COBRA election:

- A new enrollment application must be completed or a copy of COBRA acceptance notice submitted.
- The completed application should be forwarded to the Plan within 60 days of the qualifying event for processing. Prior to forwarding the completed application to the Plan, please ensure that the “COBRA” election box is checked and the correct COBRA effective date is indicated.
- The employer is responsible for collecting premium payments from the COBRA member. In the event the member does not make a premium payment to the group within 31 days of the due date he/she should be canceled and the cancellation should be noted on the Group Statement and submitted to the Plan.
- The employer must determine and monitor the length of time a member may be eligible for COBRA coverage.
- When COBRA coverage exhausts or the member elects to terminate coverage, he/she should be canceled and the cancellation should be noted on the Group Statement and submitted to the Plan.

The Plan emphasizes that this is an employer law. We are providing information in an attempt to help with compliance only. If additional advice or information is needed, we suggest contacting your company’s legal office or attorney; or you may call the United States Department of Labor Pensions and Welfare Benefits Administration at 202-219-8776 or toll free at 1-866-275-7922.

It is the Plan’s responsibility to:

- Process completed COBRA applications upon receipt.
- Bill the employer for all COBRA participants under a COBRA subgroup.

Individual Health Plans

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

Individual Conversion / 90-Day Continuation of Coverage

Each contract year large and small group employers will be given the choice of offering Individual Conversion or 90-day Continuation of Coverage for their members who lose eligibility under the group plans. Employers and members can refer to their coverage documents for complete details and requirements.

Option 1: Conversion from the group coverage to an individual conversion policy

The application for the policy must be made, and the first premium paid to the insurer, within thirty-one days after the employee’s coverage ends. The conversion policy will extend coverage to the same family members that were insured under the group policy. Other than newborns, no

new family members may be added to the conversion policy. No new pre-existing condition exclusions may be applied other than those that remain unexpired under the group plan.

Option 2: Continuation of Coverage under the group policy for a period of ninety days immediately following the date of the termination of the person's eligibility, without evidence of insurability

The application for the extended coverage is made to the group policyholder and the total premium for the ninety-day period is paid to the group policyholder prior to the termination. 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 months' period immediately preceding termination of eligibility.

Medicare

Optima Health offers a Medicare Advantage Plan (Optima Medicare) to all eligible Medicare beneficiaries. Optima Medicare is a Local PPO, Medicare Advantage Plan serving 60 counties in Virginia. To become certified to sell the Optima Medicare Plans and learn more about Medicare Advantage Plans with Optima Health please contact Kathy McVey at 757-552-7302 or go to optimahealth.com/medicare.

ENROLLMENT APPLICATION CHECK POINTS

The information requested on the Enrollment Application/Coordination of Benefits is essential to ensure coverage for the new member, accurate billing, and coordination of benefits with other insurance carriers. **All information on the application must be complete before submission for processing.** A short summary of major checkpoints is included below for various situations. In all cases, enrollment applications must be submitted to the Plan within 31 days of the qualifying event.

(1) New Hires

- Employee has completed eligibility waiting period.
- Enrollment application is completed with an indication of whether or not the applicant has additional health insurance. The applicant must also complete the Coordination of Benefits form if he or she has additional health insurance coverage.
- Employee's date of hire and requested effective coverage date is indicated on application.
- Group/subgroup number is provided on application.
- Any necessary documentation is attached.
- Certificate of Creditable Coverage for employee and all covered dependents is provided.
- Application is signed by Benefits Administrator and employee.

(2) New Spouse

- Enrollment application/Coordination of Benefits is completed.
- Copy of marriage certificate is attached.
- Application is signed by Benefits Administrator and employee.

(3) Newborn

- Enrollment application/Coordination of Benefits is completed.
- Date of birth is indicated on application.
- Copy of birth registration (provided by hospital) is attached.
- Application is signed by Benefits Administrator and employee.

(4) Adopted Child/Child in Legal Custody

- Enrollment application/Coordination of Benefits is completed.
- Date of adoption/court order is indicated on application.
- Copy of adoption papers or custody order is attached.
- Application is signed by Benefits Administrator and employee.

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

Member Termination Guidelines

Written notification of termination must be received by the Plan on or before the 15th of the following month when members become ineligible for coverage. (For example, the Plan must receive written notification from the group by September 15th for a requested termination date of August 31).

Retroactive terminations may occur up to 30 days after the member becomes ineligible, and any related premiums will be refunded, provided the member did not incur claims during the period of ineligibility.

If the member incurs claims after becoming ineligible for coverage and the Plan is not notified within 15 days of the requested termination date, there will be no refund of premiums paid or due to the Plan by the group.

The employer group should delete the member from the regular Group Statement at the time of termination.

Disenrollment Guidelines

Subscribers

- Follow the termination guidelines outlined above
- Submit a written request of termination to the Plan in one of the following ways:
 - a) Fax, mail, or email a request to the Plan on company letterhead. Provide member name, member number, and requested date of termination.
 - b) Complete an enrollment application by marking the box titled “cancel all” and indicate the requested date of termination.
 - c) Line through the name of the terminated subscriber on the Group Bill. Also indicate the name of the terminated subscriber and the date of termination on the Group Reconciliation Statement section of the bill.

Reinstatement Guidelines (completed application required)

- An employee who returns to work with no more than a 63-day break in coverage will have the same employment and eligibility status as before.
- An employee who returns to work within 90 days after an approved leave of absence will keep the same employment and eligibility status as before.
- An employee who returns to work after 90 days will be considered a new employee and will be subject to all eligibility requirements, including any pre-existing condition exclusions, waiting periods, and effective date of coverage requirements.

Primary Physician Changes

If the Plan requires a primary care physician (PCP) selection at the time of enrollment, members may change their PCP by visiting the Plan’s Web site at www.optimahealth.com or by calling Member Services at the number on their member ID card. They will be sent a new ID card listing the new PCP within 7 to 10 business days of the request.

Although members are encouraged to develop a long-term relationship with their PCP, the Plan does not impose a limit to the number of PCP changes that can be made during the Plan year.

Provider Directories are available at the Plan’s Web site.

Understanding the Group Billing Statement

A group bill consists of four parts, if applicable:

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

Other important billing information:

- **Group billing:** Group billing is calculated on a full month proration basis. The group will be billed a full month's premium for any member whose coverage is effective for any portion of the month.
- **Grace period:** The Plan allows a 31-day grace period for the payment of premiums. Failure to pay premiums within the grace period may result in termination of your group's coverage.
- **Checks returned for non-sufficient funds:** Group coverage may also be terminated if a premium check is returned for non-sufficient funds. If a group is reinstated following a non-sufficient fund termination, future premiums must be paid with certified funds. A \$25 service charge will also be applied for checks returned for this reason.
- **Reinstatement:** The Plan will allow for reinstatement of a group health plan with payment of all past due and current premiums within 15 days of the date of termination. Groups that have been terminated for non-payment three times in a 24 month period are ineligible for reinstatement.
- **Renewal Bills:** Each year, at the employer group's anniversary period, the monthly billing will be slightly delayed until the anniversary period ends. This is to allow adequate time for re-enrolling the group and subscribers.

Contact Us

Web site

Visit www.optimahealth.com to:

- View a list of Plan providers
- Change your Plan primary care physician (PCP)
- Update your home address, phone number, or email address
- Order a new member ID card
- View your claims history
- View your benefits
- View your authorizations
- Download member forms
- Learn about member discounts
- Manage your pharmacy benefit (if administered by Optima Health)
- Research drug options and pricing
- Choose to receive your Explanation of Benefits (EOB) electronically
- Research conditions, treatment options, and hospital quality
- Link to www.optimabehavioralhealth.com

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

Email

members@optimahealth.com

Please note: Members who register and sign in to optimahealth.com can contact Member Services securely using the Contact Us form.

Phone

Member Services

Call the number listed on your Member ID card.

Office hours: Mon. – Fri., 8 a.m. to 7 p.m.
After business hours, please leave a message.

Behavioral Health Services

1-800-648-8420

Mail

¹³
Optima Health Member Services
4417 Corporation Lane
Virginia Beach, VA 23462

TDD lines for the hearing-impaired

1-800-225-7784

Language services for non-English speaking members

Call the number listed on your Member ID card to access language services.

After Hours Nurse Advice Line

Call the number listed on your Member ID card.

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

Frequently Asked Questions (FAQs)

How do I register on optimahealth.com?

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

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

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

If you forget your username, you will need to go through the registration process again.

If you forget the password, go to "Change Password" to reset it. The secret answer to a secret question chosen in the registration process will allow you to reset the password. The answer to the secret question is case sensitive. If you do not remember the secret question and answer, you will need to re-register or contact Member Services to have your password reset.

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

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

How do I know my information is safe/secure?

We are required by law to:

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

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

How do I allow my spouse to view my claims?

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

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

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

How can I access my child's pharmacy claims?

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

How do I know if my prescription drug is covered?

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

Where do I find benefit information?

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

Plans Offered

Optima Health offers several plan options to meet our customer's needs. This Benefit Administrator Guide outlines basic information to common questions about the health plans available. Remember, specific Plan information such as Copayment, Coinsurance, and applicable Deductibles are referenced in the specific plan benefit, a benefit structure that is chosen by the employer. Contact your current agent or broker for further information regarding Plan options.

Optima Vantage

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

Optima Foursight

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

Optima Equity

A Preferred Provider Organization (PPO) with a high-deductible health plan (HDHP) that lets members contribute to a Healthcare Spending Account. Employees are eligible to make pre-tax contributions to the HSA account.

Optima Design

Optima Design Healthcare Reimbursement Arrangement offers employers the simplicity of a fully integrated health plan and HRA funding option combined with the flexibility employers need to design the HRA to achieve their goals.

Employers can offer a variety of core benefit plans which, when partnered with an HRA, incent employees to manage their healthcare dollars and helps employers to better control and predict healthcare costs.

Optima Plus

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

In-network:

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

Out-of-network:

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

Optima Individual Health Plans

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

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

Optima Medicare Plans

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

Family Access to Medical Insurance Security Plan (FAMIS)

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

Optima Family Care

Optima Family Care is a health plan that will work in partnership with the Commonwealth of Virginia to provide the benefits of the FAMIS Plan. Family Care is a Health Maintenance Organization (HMO), committed to providing courteous, professional, and quality care. For additional information regarding Optima Family Care, please call Member Services from 8:00 a.m. until 7:00 p.m. at 757-552-8975 or 1-800-881-2166 (Monday through Friday).

BENEFIT INFORMATION