

April 2011

Broker Guide



INTRODUCTION

At Optima Health, we are proud to partner with you in growing your business. We celebrated our 25th anniversary in 2009, and since then we have grown our membership to over 430,000 members, thanks to all of you. Each day we strive to make it easier to do business with us through new technologies and simplified processes, while never losing sight of exemplary customer service. Our team focuses on the market to ensure we continue to offer the best healthcare solutions for your clients especially as the economy changes. We appreciate the trust you place in us each time you recommend us to your clients.

We are pleased to release the updated Optima Health Broker Guide. This agent's manual 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. If you have additional questions that are not covered in this guide, please contact your sales representative for further assistance.

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

**Optima Health
4417 Corporation Lane
Virginia Beach, VA 23462
(757) 687-6030
(877) 552-7401 – Toll-free for Hampton Roads
(866) 575-4475 – Toll-free for Virginia State-wide**

**(757) 687-6031 Fax
OptimaHealth.com**

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.

Small Group (2-99 eligibles) Enrollment and Underwriting Guidelines

Employers, Employee, and Dependent Eligibility2

- Eligible Employers & Employees
- Employees NOT Eligible
- Out-of-Area Employees
- Eligible Dependents
- Dependents NOT Eligible
- Dependent Verification
- Member Plan Changes
- Pre-existing Condition Guidelines
- Creditable Coverage
- Proof of Prior Coverage
- HIPAA Special Enrollment Provisions
- Effective Date of Coverage

Policies/Procedures for Groups Applying for Coverage9

- Employer Contribution
- Principal Ownership Companies
- “Class” Groups
- Waiting Periods/Contributions
- Participation Requirements
- Employer Application & Employee Application/Health Questionnaire
- Waivers
- Virginia Employment Commission Quarterly Wage and Earnings Report
- Misstatement of Age or Class
- Premium Check/Payments
- Work Related Illness and/or Injury

Underwriting Guidelines/Policies/Procedures 13

- Small Group New Business
- Risk Acceptance
- Declination of Quote
- Additional UW Requirements/Information
- Under Contract Groups
- Membership Changes
- Retroactive Disenrollment
- Plan Changes
- Premium Payments
- Reinstatement of Groups Terminated for Non-payment of Premium
- Renewal Proposals

Large Group (100+ eligibles) Enrollment and Underwriting Guidelines

Employers, Employee, and Dependent Eligibility 21

- Eligible Employers & Employees
- Employees NOT Eligible
- Out-of-Area Employees
- Eligible Dependents
- Dependents NOT Eligible
- Out-of-Area Dependent Children
- Dependent Verification
- Member Plan Changes
- Pre-existing Condition Guidelines
- HIPAA Special Enrollment Provisions
- Creditable Coverage
- Proof of Prior Coverage

Contents

- Policies/Procedures for Groups Applying for Coverage 26**
 - Employer Contribution
 - Principal Ownership Companies
 - “Class” Groups
 - Participation Requirements
 - Misstatement of Age or Class
 - Work Related Illness and/or Injury
 - Risk Acceptance
 - Size and Underwriting Limits
 - Request for Proposals
 - Premium Check/Payments

- Continuation of Coverage 29**
 - Continuation of Coverage During Absence From Employment
 - COBRA
 - Individual Health Plans
 - Individual Conversion / 12 Month Continuation of Coverage
 - Medicare

- Medical Loss Ratio Rebate Distribution 33**

- Group Broker Policies & Procedures 35**
 - Agent/Broker Appointment Policy
 - Commissions Policy & Schedule
 - AOR/BOR Change Letter
 - Proposal Preparation for Brokers

- Substitute Form W-9 (SF-W9) 41**

- Virginia Bureau of Insurance Information 44**
 - Administrative Letters
 - Virginia Bureau of Insurance Site Map

Small Group Enrollment and Underwriting Guidelines

Small Group (2-99 eligibles) Enrollment and Underwriting Guidelines

Employers, Employee, and Dependent Eligibility

Eligible Employers

- Corporations, partnerships, or sole proprietorships with a clear employer/employee relationship. Note that 1099 employee relationships are not eligible for group coverage.
- Financially stable business organizations with at least two eligible employees (including owners and partners), but not more than 99 eligible employees.
- Employers with a payroll deduction system established for employee contributions.
- The employer group must not have been formed for the sole purpose of securing insurance.
- The employer group must be 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.
- An employer group who would otherwise be eligible for coverage under an Optima 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:

1. is employed by the group; and
 2. resides or works in the service area or is an out-of area employee (and no more than 35 percent of the eligible and enrolled employees are out-of-area); and
 3. is actively at work performing all of his/her usual occupation duties; 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 date of initial eligibility, files a complete enrollment application (paper, electronic, or web), 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.
- The employee must appear on the employer's most recent Virginia Employment Commission Quarterly Report. Employers must provide proof of true and active employee status for employees not listed (new-hires, owners) on most recent Virginia Employment Commission Quarterly Wage and Earnings Report (VEC).
 - 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 2 person group, or any other group not required or able to submit a Virginia Employment Commission Quarterly Wage and Earnings Report (VEC) 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
 - Payroll Summary
- For current groups, the employees must meet the new-hire waiting period established by the employer. New groups can waive the new-hire waiting period at the time of the group's initial enrollment with Optima Health Plan (OHP) or Optima Health Insurance Company (OHIC), but only if they do so for all of the employees. After initial enrollment, **the new-hire waiting period can only be changed at renewal.**

Employees NOT Eligible

- 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, which cannot be any less than 25 hours per week), leased, temporary, seasonal, retired, or pensioned 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 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 35 percent of the covered employees can be covered under the OOA PPO. If more than 35 percent 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, 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 their PPO plan.

Eligible Dependents

- The legal spouse of the insured employee.
- Children up to the end of the month in which they turn age 26 (26 EOM). Eligible children include:
 - Natural or step children;
 - Legally adopted children;
 - Children placed with you for adoption;
 - 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 except that for plan years beginning before January 1, 2014 plans may exclude a child from coverage if the child is eligible to enroll in an employer sponsored health plan other than a group health plan of a parent.

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.

- 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

- Any spouse or child in the military service or government service of any country
- Dependent children over age 26 EOM
- Any spouse or child who is insured as an employee of the same employer
- Grandchildren for which the employee does not have legal custody
- Individuals no longer legally married to an eligible employee
- Domestic partners

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 (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
- 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 standard* 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".

* 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.

Special Enrollment Opportunity for Children under Age 26 EOM, for groups new or renewing after 9/23/10.

Children under age 26 EOM that aged off their parent's health plan or were not allowed to enroll because they did not meet their plan's dependent age requirements are eligible to enroll in the Plan during a 30 day special enrollment period. Individuals may request enrollment for such children for 30 days from the date of notice of special enrollment. If the child is enrolled during the special enrollment period coverage will be effective on the first day of the Plan's coverage. Children who do not enroll during the special enrollment period will have to wait until the Plan's next open enrollment period or a qualifying event.

Lifetime Limits and Opportunity to Enroll

Individuals whose coverage ended by reason of reaching a lifetime limit under the Plan will have an opportunity to enroll in the Plan. Individuals have 30 days from the date of notice of special enrollment to request enrollment. For individuals who enroll under this opportunity, coverage will take effect not later than the first day of the Plan effective date.

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.

For groups new or renewing after 9/23/10, the pre-existing condition waiting period does not apply to:

1. A newborn, adopted child under age 19, or a child under age 19 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 19 years and older 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.

Pre-existing condition exclusions will not apply to children under age 19.

Pre-existing condition exclusion means a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan or group or individual health insurance coverage (or other coverage provided to Federally eligible individuals pursuant to 45 CFR part 148), whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A pre-existing condition exclusion includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan, or group or individual health insurance coverage (or other coverage provided to Federally eligible individuals pursuant to 45 CFR part 148), such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

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:

1. Group health plans, including COBRA continuation coverage;
2. 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);
3. Individual coverage;
4. Medicare Part A or B;
5. Medicaid;
6. Military service related care such as CHAMPUS;
7. A medical care program of the Indian Health Service or of a tribal organization;
8. A state health benefits risk pool;
9. A health program offered under the Federal Employees Health Benefits Program;
10. 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;
11. A health plan offered under the Peace Corps Act; and

12. 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.

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.

For Optima Health Plan products, 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. For Optima Health Insurance Company products, newborns will be covered from the moment of birth for 31 days and 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 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.

Policies/Procedures for Groups Applying for Coverage

Employer Contribution

On a monthly basis, the employer must contribute a minimum of 50 percent 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).
- 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 demonstratable 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 Patient Protection and Affordable Care Act applies the non-discrimination requirements that currently apply to self-insured group health to fully insured plans effective on the first plan year that begins on or after September 23, 2010. 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 percent owners, and the highest paid 25 percent 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 can be subject to financial and tax penalties.

Groups with 51-99 eligible 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 offer coverage to. Participation must be no less than 75 percent 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 of 2 - 99 eligibles may elect to have different new hire waiting periods and/or employer contributions for different classes.

Participation Requirements

Firms with only two or three employees are required to have 100 percent participation. Groups with four or more are required to have 75 percent participation of eligible employees. Employees who waive coverage to stay on another qualifying plan (such as Medicare, CHAMPUS, or a spouse's employer-sponsored plan) are not considered eligible employees for the purpose of the participation calculation, and will not count against the group's participation. To determine group participation:

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

75 percent participation would require that 15 of the 20 potential enrolling employees participate on the plan. Participation is a continuing requirement. Participation requirements must be met at the time the group is underwritten, and throughout their 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.

Employer Application

The Employer Group Application must be submitted by every group 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/Health Questionnaire for Groups with 2 – 24 Enrolled Employees

Each employee applying for coverage must complete an Employee Application/Health Questionnaire. The Application/Health Questionnaire must be completed and signed by the employee and Benefits Administrator. When requesting coverage for dependents, their enrollment and health information must also be provided. NOTE: All sections of the Application/Health Questionnaire must be completed prior to submission. Incomplete Applications may be returned to the employee for completion and may delay the underwriting and/or enrollment process.

Optima Health Plan and Optima Health Insurance Company will not accept any Employee Application/Health Questionnaire 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 only be eligible for coverage 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. A 12-month pre-existing condition period may apply. Please refer to the Pre-Existing Condition guidelines for more information.

New applications submitted for an effective date within 90 days of the group's initial effective date, or renewal date, may require the group to be resubmitted to underwriting for re-evaluation and rate adjustment.

NOTE: The Bureau of Insurance (BOI) Small Group Universal Application (Virginia Group Health Insurance Medical History Form) is acceptable for Optima Health to provide a quote to an Employer Group; however, Pages 1 and 2 of the Optima Health Employee Application/Health Questionnaire is required for 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.

Employer Group Health Questionnaire and Employee Applications for Groups with 25+ Enrolled Employees

Groups with 25 or more enrolled employees 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)
- Sex of Employee (required)
- Social Security Number of Employee and dependants (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 Pages 1 and 2 of the Optima Health Employee Application/Health Questionnaire for the enrollment process. These pages must be completed and signed by the employee and the Benefits Administrator. When requesting coverage for dependents, their enrollment information must also be provided. **NOTE: The medical information section (Pages 3 and 4) of the Application does not need to be submitted. Incomplete applications may be returned to employee for completion and may delay the enrollment process.**

Optima Health Plan and Optima Health Insurance Company will not accept any Employer Group Health Questionnaire signed and dated more than 90 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. A 12-month pre-existing condition period may apply. Please refer to the Pre-Existing Condition guidelines for more information.

Waivers

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

- Self, which will include all dependents
- Spouse only
- Child or children only
- Spouse and child or children
- Reason for waiver
 - Carrier and Policy of other insurance if reason for waiver is other insurance (Optima Health reserves the right to verify other insurance coverage).

Virginia Employment Commission Quarterly Wage and Earnings Report

Along with the completed Employer Group Application and individual Employee Application/Health Questionnaires or Employer Group Health Questionnaire, groups applying for coverage must also supply (may be required prior to submission for underwriting) a copy of the group's most recent Virginia Employment Commission Quarterly Wage and Earnings Report (VEC).

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

- 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)
- 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 that are 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) or,
- IRS Form 1120
- Payroll Summary

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

Misstatement of Age or Class

If the age, sex, or level/tier of coverage of any insured employee has been misstated, the member's correct age, sex, 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 Optima Health Plan or Optima Health Insurance Company) 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.

Optima Health Plan and Optima Health Insurance Company 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 with two employees are not required to maintain a Workers' Compensation policy. Claims for work related illness/injury for enrolled employees of a 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 insurance policy. 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.

Underwriting Guidelines/Policies/Procedures

Small Group New Business

Small Group is considered to be employer groups with 2 – 99 eligible employees. The eligible count includes employees waiving coverage. The number of eligible employees is the determining factor when it comes to differentiating if a group is small group vs. large group, not the number of employees actually enrolling.

Please allow no less than five (5) business days for the completion of underwriting. Occasionally additional information may be required for the purposes of underwriting which may increase the turn around time for final rate determination, for example, a request for Attending Physician Statement(s). Return of incomplete Applications to 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 1st of the month effective date will need to be submitted to underwriting prior to the close of business on the 5th of the effective month. All additional information necessary for enrollment will need to be complete prior to the close of business on the 10th of the effective month.

Groups requesting a 15th of the month effective date will need to be submitted to underwriting prior to the close of business on the 20th of the effective month. All additional information necessary for enrollment will need to be complete prior to the close of business on the 25th of the effective month.

The following items are required to complete the underwriting process:

- Employer Group Application.
- Groups w/ 2 – 24 enrolling employees: Complete Employee Application/Health Questionnaires for every employee who is applying for coverage. **Applications/Health Questionnaires must be signed and dated by applicant prior to underwriting.** NOTE: Any applications signed more than 90 days prior to the effective date will require a new, updated application.
- Groups w/ 25+ enrolling employees: Employer Group Health Questionnaire, Group Census, Current Benefit Structure(s), and Current and Renewing Rates for all active plans. Pages 1 and 2 of the Optima Health Employee Application/Health Questionnaire will be required for all employees applying for coverage at enrollment.
- Waivers for eligible employees who are not electing coverage.
- VEC, Declaration letter, or other required eligibility documentation.
- Proof of prior coverage for employees enrolling on plans subject to Pre-Existing Conditions.

The Underwriters may conduct a personal history interview with the Subscriber and/or Subscriber's spouse regarding medical information provided. Medical evaluation of the group is based on the following three risk categories:

1. **Known** – Any chronic medical condition that requires medication on a regular basis (i.e. hypertension, diabetes, elevated cholesterol, etc.). The Underwriter will "price out" the cost of every prescription currently being used by any member of the group. The Average Wholesale Price (AWP) for the 12-month contract period is calculated and the pharmacy Copayments are deducted. Also included in the "known" grouping would be pending surgeries or procedures, pregnancies, ongoing therapies, durable medical equipment, and home healthcare services.
2. **Probable** – Any progressive disease or disorder that historically leads to complications. The complications are sometimes due to the natural progression of the condition or can also be due to non-compliance by the member. An example of non-compliance could be a diabetic who does not check blood sugar levels on a regular basis, or follow the physician recommended dietary guidelines. In a non-compliant or poorly managed situation the risk may be higher due to the accelerated progression of the disease.
3. **Potential** – Any acute or chronic condition that has some potential for complications. It is very important for the underwriter to evaluate these conditions when determining the degree of risk to assign to the group. For example, a person who has had a Coronary Artery Bypass Graft (CABG) has the (rare) potential for the graft to fail.

The costs used to assess risk are based on fees negotiated with our contracted pharmacies, facilities, and medical providers. The risk assessment is confidential and under no circumstances will any medical information about any member be given to the broker or the group. The Account Executive that is working with the agent or broker will act as the liaison between the agent or broker and the Underwriter for the group. The agent or broker should not contact the Underwriter directly. The Underwriter or Small Group Underwriting Manager will review questions regarding any underwriting decision.

Risk Acceptance

Optima Health Plan and Optima Health Insurance Company's 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 Optima Health Plan or Optima Health Insurance Company's sole judgment, the omitted information was material to the person(s)' or group's eligibility or insurability.

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 Optima Health Plan or Optima Health Insurance Company's sole judgment, 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 Optima Health Plan or Optima Health Insurance 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.

Optima Health Plan and Optima Health Insurance Company may terminate coverage if:

- Either company determines that information obtained throughout the group's enrollment is material to the group's current eligibility or insurability;
- Such information is in regard to current or previous compliance (or non-compliance) with the policies, procedures, and/or guidelines of either Optima Health Plan or Optima Health Insurance Company.

New Employee Applications/Health Questionnaires submitted within 90 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.

Declination of Quote

Prospective groups with 51-99 eligible employees that either do not provide Optima with enough information to make a sound underwriting decision or do not prove to be a viable group for Optima to insure, will be declined for quoting.

Additional information may be submitted for further review, but providing additional information does not guarantee an underwriting quote.

Additional Underwriting Requirements/Information

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

Groups with 2 – 14 employees will be rated using age/gender banding. Groups with 15 or more will be rated using composite rating methodology.

Groups requesting two plan offerings must have a minimum of 5 enrolling employee subscribers. Groups requesting three plan offerings must have a minimum of 15 enrolling employee subscribers, or five enrolling employee subscribers if the third option is an Equity CDHP. A surcharge may apply for selecting more than one benefit offering. Note: HMO Plans are not available in all service areas.

Groups that have a change in their enrollment that would change which rating structure would apply (age/gender band vs. composite) will be changed to the appropriate rate structure.

Rates presented on proposals reflect current census data. Birthdays occurring prior to 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 small group (2 – 99 eligibles) that increase their employee base to 100 or more eligibles 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 as a small group vs. large group. The same review will apply to large groups that fall below 100 eligibles 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 give 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 (2) enrolled employees. A group falling to 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

Prior to July 1, 2011:

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 two months 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 owed.

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.

Effective July 1, 2011:

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 in 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, and those 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 effective 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 (2) months of premium payments made by the Group on behalf of the ineligible member.

For Example: If notification is received no later than January 31st for a requested termination date of November 30th, and the member has made no premium contribution, and no claims have been incurred, Optima Health will authorize retro termination 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 30th and the member has made no premium contribution, and no claims have been incurred, Optima Health will authorize 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 PPACA, and all state healthcare 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. "PPACA" means the Patient Protection and 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 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.

Due to health reform, any group that enrolled or renewed prior to 10/1/2010 and is requesting a benefit change for an effective date of 10/1/2010 or later will be considered an INCREASE in benefit value. Therefore, the group will be re-underwritten and new rates will be issued and a new 12-month contract will ensue.

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.

Renewal Proposals

Proposals for renewing groups will be prepared and forwarded to the current Agent or Broker of Record (AOR/BOR) 30 - 60 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 their group.**

NOTE: Groups receiving a **35 percent or greater** premium increase must receive their renewal rates at least **60** days prior to their anniversary date. Groups receiving **less than a 35 percent** premium increase must receive their rates at least **30** days prior to their anniversary date.

The AOR/BOR is required to notify their OHP/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/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

Large Group (100+ eligibles) 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.)
- Financially stable business organizations with at least 100 eligible employees (including owners and partners).
- Employers with a payroll deduction system established for employee contributions.
- The employer group must not have been formed for the sole purpose of securing insurance.
- An employer group who would otherwise be eligible for coverage under an Optima Health Group Plan may nonetheless be ineligible if by 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:

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 (paper, electronic, or web), 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 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

- 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.
- 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.
- Children up to the end of the month or end of year in which they turn age 26 (26 EOM/EOY) depending on what is requested and underwritten. Eligible children include:
 - Natural or step children;
 - Legally adopted children;
 - Children placed with you for adoption;
 - 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 except that for plan years beginning before January 1, 2014 plans may exclude a child from coverage if the child is eligible to enroll in an employer sponsored health plan other than a group health plan of a parent.

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.

- 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.

Dependents NOT Eligible

- Any spouse or child in the military service or government service of any country
- Dependent children over age 26 EOM/EOY. (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 employer
- Grandchildren for which the employee does not have legal custody
- Individuals no longer legally married to an eligible employee

Out-of-Area 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 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 at the group's next renewal date.

Group's 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 (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
- 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 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. 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 for any charges for claims for services during the period of ineligibility.

Member Plan Changes

Members may only enroll for benefits or change benefits once per year during the open enrollment period. Exceptions are allowed for HIPAA "Special Enrollment Provisions" (Qualifying Life Events).

Special Enrollment Opportunity for Children under Age 26 EOM/EOY, for groups new or renewing after 9/23/10.

Children under age 26 EOM/EOY that aged off their parent's health plan or were not allowed to enroll because they did not meet their plan's dependent age requirements are eligible to enroll in the Plan during a 30 day special enrollment period. Individuals may request enrollment for such children for 30 days from the date of notice of special enrollment. If the child is enrolled during the special enrollment period coverage will be effective on the first day of the Plan's coverage. Children who do not enroll during the special enrollment period will have to wait until the Plan's next open enrollment period or a qualifying event.

Lifetime Limits and Opportunity to Enroll

Individuals whose coverage ended by reason of reaching a lifetime limit under the Plan will have an opportunity to enroll in the Plan. Individuals have 30 days from the date of notice of special enrollment to request enrollment. For individuals who enroll under this opportunity, coverage will take effect not later than the first day of the Plan effective date.

Pre-Existing Condition Guidelines (For Groups Without Proof of Prior Coverage)

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.

For groups new or renewing after 9/23/10, 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 exclusions will not apply to children under age 19.

Pre-existing condition exclusion means a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan or group or individual health insurance coverage (or other coverage provided to Federally eligible individuals pursuant to 45 CFR part 148), whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A pre-existing condition exclusion includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date

of coverage (or if coverage is denied, the date of the denial) under a group health plan, or group or individual health insurance coverage (or other coverage provided to Federally eligible individuals pursuant to 45 CFR part 148), such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

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.

Creditable Coverage

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:

1. Group health plans, including COBRA continuation coverage;
2. 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);
3. Individual coverage;
4. Medicare Part A or B;
5. Medicaid;
6. Military service related care such as CHAMPUS;
7. A medical care program of the Indian Health Service or of a tribal organization;
8. A state health benefits risk pool;
9. A health program offered under the Federal Employees Health Benefits Program;
10. 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;
11. A health plan offered under the Peace Corps Act; and
12. 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.

Policies/Procedures for Groups Applying for Coverage

Employer Contribution

On a monthly basis, the employer must contribute a minimum of 50 percent 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).
- 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

The Patient Protection and Affordable Care Act applies the non-discrimination requirements that currently apply to self-insured group health to fully insured plans effective on the first plan year that begins on or

after September 23, 2010. 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 percent owners, and the highest paid 25 percent 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 can be subject to financial and tax penalties.

Participation Requirements

Groups are required to have 75 percent 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, CHAMPUS, or a spouse's employer-sponsored plan) are not considered eligible employees for the purpose of this calculation.

Participation is a continuing requirement. Failure to maintain the applicable participation level may result in termination of coverage. Renewal of a group may be contingent upon re-verification of group's employee participation.

Misstatement of Age or Class

If the age, sex, or insurance class of any insured employee has been misstated, the member's correct age, sex, or class 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.

Work Related Illness and/or Injury

Work related illnesses and/or injuries are not covered by Optima Health Plan or Optima Health Insurance Company group policies for groups with more than 3 employees.

Risk Acceptance

Optima Health Plan and Optima Health Insurance Company's approval of coverage for eligible employees or dependents is subject to 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, will result in the termination of coverage if, in Optima Health Plan or Optima Health Insurance Company's sole judgment, the omitted information was material to the person's or group's insurability.

Size and Underwriting Limits

Large group is considered to be employer groups with 100 or more eligible employees. The number of eligible employees is the determining factor when it comes to differentiating if a group is small group vs. large group, not the number of employees actually enrolled.

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

Companies originally written as large groups that decrease their employee base to fewer than 100 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. small group. The same review will apply to small groups that increase above 99 eligible employees during the contract year.

Request For Proposals

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

- Complete and accurate employee census – showing DOB, gender, tier, plan, and zip code.
- Current rates.
- Current plan design(s).

The following information is needed to receive the **most competitive** quote from Optima Health:

- Groups current and renewal rates.
- Current and proposed renewal benefit summaries, noting changes.
- Benefit summaries and rates for the experience period, noting any changes in the experience period.
- Completed Optima Health Employer Group Health Questionnaire signed by the employer or benefits administrator.
- 24 months of claims experience with corresponding employee and member enrollment by month
- High claimant information which must be the same experience period as the claims.
- Carrier history.
- Employer contribution.

Premium Check/Payments

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

Optima Health Plan and Optima Health Insurance Company will not accept personal checks from the Agent or Broker in lieu of a check from the employer group.

Continuation of Coverage

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 Benefit Administration at 202-219-8776 or toll-free at 1-866-275-7922.

It is the Plan's responsibility to:

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

Individual Health Plans

Employees and dependents who are no longer eligible for coverage through an employer group, may apply for an Individual Health Plan. Inquiries, applications, or additional information may be obtained by contacting Optima Health. Information is also available through the Plan's Web site optimahealth.com/individual.

Individual Conversion / 12 Month Continuation of Coverage

Groups with fewer than 20 eligible employees will be given the choice each year of offering Individual Conversion or Continuation of Coverage for their employees who lose eligibility under the group plan. Employers and members can refer to their coverage documents for complete details and requirements.

Groups with 20 or more eligible employees have only an Individual Conversion option. Refer to Option 1 below for details.

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 12 months 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 within 31 days after issuance of the written notice but not to exceed the 60 day period following the date of 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 months' 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 or Conversion 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.

Model Notices for employers are available from the BOI.

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 Optima Health or go to optimahealth.com/medicare.

Medical Loss Ratio Rebate Distribution

Medical Loss Ratio Rebate Distribution

Medical Loss Ratio Rebate Distribution

Under the Affordable Care Act (“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 Optima Health’s MLR fails to meet the minimum requirements set by ACA, Optima Health shall provide any such MLR rebate directly to the Group Policy Holder. [Optima Health's MLR will be calculated at the book of business level within the Virginia state classification definitions of Small Group \(2 to 49 employees\) and Large Group \(50+ employees\) for each of our legal entities \(Optima Health Plan and Optima Health Insurance Company\).](#) The Group is solely responsible for distribution of any MLR rebate to the applicable Group Plan enrollees subject to the following conditions:

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

Broker
Policies and Procedures

Broker Policies and Procedures

Agent/Broker Appointment Policy

Appointment Policy Statement

Optima Health Plan (OHP) and Optima Health Insurance Company (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 & Health license from the Commonwealth of Virginia. The following need to be submitted to obtain appointment:

- a) A copy of the Life & Health license or Certifying Letter for the Agent/Broker
- b) A copy of the Life & Health license for the Agency or Certifying Letter (if commissions are to be paid to an Agency)
- c) An executed Broker Agreement
- d) A completed Substitute Form W-9

NOTE: Optima Health Plan **and** Optima Health Insurance Company **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 Optima Health Plan and Optima Health Insurance Company.

Points to Remember

- If an Agent/Broker assigns payment of commissions to an Agency, both the Agent/Broker and Agency must be listed as the Agency of Record and both 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 will be terminated.
- Optima Health Plan and Optima Health Insurance Company 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 Bureau of Insurance regulations and laws as outlined in the *Bureau of Insurance Administrative Letter 2002-1*, included in this Guide.

Commissions Policy and Schedule

Commissions Policy Statement

Optima Health will pay commissions to any broker who is appointed with Optima Health, in good standing with the Bureau of Insurance (BOI), and is designated as the Agent or Broker of Record by a group.

Guidelines

- Commissions will be paid, starting with the first premium paid, after Optima Health receives notification of appointment from the BOI. Commissions will not be paid retroactively for premiums received before the appointment date or for months invoiced prior to an AOR/BOR change or prior to the appointment date.
- The maximum number of brokers allowed to split commissions on a group is two. The split can be of any variation between the two brokers on the group (i.e. 50/50; 60/40; 70/30). If the brokers splitting the commission on the group are operating through the same agency, the check will be mailed to the agency, which will then be responsible for disbursing payment to the brokers.
- Commissions will continue to be paid to the Agent of Record as long as the agent remains licensed and in good standing for Life & Health with the Virginia BOI. If the BOI revokes an agent's license for any reason, commissions will terminate with the last premium received by OHP or OHIC prior to the termination date. Agents voluntarily forfeiting their licenses will be paid commissions through the next renewal date of the group, or until such time as an agent/broker change letter is received by Optima Health. **Please note that this is not a policy of the Commonwealth of Virginia State Corporation Commission Bureau of Insurance, but a policy of Optima Health Plan and Optima Health Insurance Company.**
- Commissions are paid to the AOR/BOR designated by the customer based on premium received. Optima Health will not advance commissions or pay commissions on an average expected annual premium basis. For information regarding current commission schedules, please refer to the Broker Commission Schedule Policy included in this guide, or included as an attachment to the Broker Agreement.
- Commissions will continue to be paid to the AOR/BOR for the term of the group's enrollment, or until: an AOR/BOR termination/change letter (as outlined in this guide) is received by Optima Health, there is notification of license termination from the BOI, there is a change to current policies and procedures outlined in this guide or amended in the Broker Agreement, or as determined appropriate by Optima Health Plan and Optima Health Insurance Company.

State and Federal Regulations

According to the Commonwealth of Virginia, State Corporation Commission, Bureau of Insurance, Code of Virginia: Agents/Agencies are not eligible to receive commission compensation on any premiums paid on new or existing business prior to licensing through the Virginia Bureau of Insurance and prior to being appointed with Optima Health Plan and Optima Health Insurance Company. All appointed agents are required to review the Administrative Letters on the BOI's Web page, <http://www.scc.virginia.gov/division/boi/webpages/boiadminltrsforagents.htm>.

Federal Law requires a customer with more than 100 contracts to disclose and file certain financial information annually. This means that as an Insurance Company, we must report to the customers the amount of commission paid to their Agent of Record. While most brokers, agents, and consultants are aware of this, it is your responsibility to explain our commission payment structure on all quotes with more than 100 contracts at the time of proposal.

Reissue of Terminated Groups

If a group is re-enrolling after a termination period of greater than 12 months, commissions will be paid at the new business commission level in place as of the new effective date of coverage.

If a group that had previously been enrolled with Optima Health Plan or Optima Health Insurance Company for one or more years is re-enrolling after a termination period of less than 12 months, with the same Agent/Broker or Agency designation in place as at the time of termination, the commission will be paid based on the renewing commission level in place as of the new effective date of coverage.

If a group that had previously been enrolled with Optima Health Plan or Optima Health Insurance Company for one or more years is re-enrolling after a termination period of less than 12 months, assigning a new Agent/Broker or Agency designation from that at the time of termination, the commission will be paid based on the new business commission level in place as of the new effective date of coverage.

If a group that had previously been enrolled with Optima Health Plan or Optima Health Insurance Company for less than one year is re-enrolling after a termination period of less than 12 months, with the same Agent/Broker or Agency designation in place as at the time of termination, the commission will be paid based on the new business commission level in place as of the new effective date of coverage for the remaining number of months that would have been paid as new under the initial group contract. After such time period, commissions will revert to the renewing commission level in place on that date.

If a group that had previously been enrolled with Optima Health Plan or Optima Health Insurance Company for less than one year is re-enrolling after a termination period less than 12 months, assigning a new Agent/Broker or Agency designation different from that at the time of termination, the commission will be paid based on the new business commission level in place as of the new effective date of coverage.

Spin-off Groups

Commission for groups forming as a result of a change in ownership, sale of division, etc. which are being established with employees from an existing "base" group will be determined by the commission level currently in place for the base group. The existing commission level will be paid regardless of the addition of employees not currently insured under the base group, and/or the introduction of a new broker.

Commission Schedule

Group Business - Effective January 1, 2007

		First Year	Renewal Years
2 - 14	Eligible*	9%	6%
15 - 24	Eligible*	7%	5%
25 - 50	Eligible*	5%	5%
51 - 99	Eligible*	3.5%	3.5%
100 - 249	Eligible*	2.25%	2.25%
250+	Eligible*	Add on	Add On

* Eligible employees not potential enrollees (that is, eligible includes employees that are waived for the participation calculation)

Commission amounts are calculated as a percentage of paid premiums.

Commissions for groups with more than 250 eligible employees are built into the rates at the time of underwriting and will affect the final rates.

Agent of Record/Broker of Record Change Letter

The AOR/BOR change will take effect on the first of the month after OHP or OHIC receives the change notification. AOR/BOR changes are also subject to the following guidelines:

- A change letter must be on company letterhead and signed by an officer of the company or the Benefits Administrator 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 Optima Health Plan and Optima Health Insurance Company and be in good standing with the Virginia Bureau of Insurance.
- 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 letter rescinded before the effective date of change by providing a letter from the group requesting that the change be cancelled.

Proposal Preparation for Brokers

Proposal Preparation Policy Statement

Optima Health Plan (OHP) and Optima Health Insurance Company (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 Agent of Record Letter, census information, submission of Optima Health Employee Application/Health Questionnaires, or a Large Group Employer Group Health Questionnaire.

The broker should allow a turnaround time of five to 10 business days for small group proposals (2 – 99 eligible) and 10 business days for large group proposals (100+ eligible).

Quote and Proposal Criteria

- Small Groups (2 – 99 eligibles) can be quoted on census information or medical information if Optima Health Employee Application/Health Questionnaires or Employers Group Health Questionnaire is submitted. Census generated proposals will be quoted on an illustrative basis only. Submission for underwriting proposals, which includes Employee Application/Health Questionnaire or Employer Group Health Questionnaire, will be quoted at the applicable medically underwritten rate level.
- Large Group (100+ eligible) proposals will be quoted based on the census and any credible claims information that can be obtained. Proposal rates will be determined by using a combination of Community Rating and Experience Rating based on the credibility of the claims experience provided. **Quotes will only be released after OHP or OHIC receives an Employer Group Health Questionnaire signed by an authorized company representative.**

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 which 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 benefit administrator/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.

Direct Broker Program

For Group Business effective as of 1/1/09

Qualification Criteria:

- Agent/Broker or Agency must have at least \$50,000 in monthly premium in the month prior to the quarter being looked at
- Agent/Broker or Agency must have at least 1 percent net contract growth over the prior quarter with a minimum of 10 net new contracts.

Bonus Payout

- \$8.00 per contract per quarter up to 5,000 enrolled contracts
- \$8.50 per contract per quarter over 5,000 enrolled contracts

This program is administered consistent with Optima Health's full-disclosure policies. All bonus amounts will be subject to appropriate taxes. Program terms are subject to change at the sole discretion of Optima Health. Sub-agents (appointed Agents who write business through one of Optima Health's General Agency relationships) are not eligible to qualify under this program.

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 reverse side of this form. We are required by the 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 31 percent federal income tax back up 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 status. 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.

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

Please return this form within 10 days or Fax to (757) 552-7396.

If you have any questions about this form, call (757) 552-7217 or toll-free at (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 & Site Map

Administrative Letters that should be reviewed by every agent

SPECIAL NOTICE TO AGENTS LICENSED IN VIRGINIA

THE BUREAU OF INSURANCE REQUIRES OPTIMA HEALTH TO MAKE YOU AWARE OF CERTAIN ADMINISTRATIVE LETTERS SPECIFICALLY APPLICABLE TO YOU AS A LICENSED AGENT IN VIRGINIA. A COMPLETE LISTING OF THE BUREAU'S ADMINISTRATIVE LETTERS CAN BE FOUND, BY YEAR OF ISSUANCE, AT THE BUREAU OF INSURANCE WEB SITE AT: <http://www.scc.virginia.gov/division/boi/webpages/boiadminltrsforagents.htm> SPECIFICALLY, LICENSEES SHOULD REVIEW, AT A MINIMUM, THE FOLLOWING ADMINISTRATIVE LETTERS:

LETTER NUMBER	SUBJECT	LIFE & ANNUITIES	HEALTH	PROPERTY & CASUALTY	TITLE
1981-15	Adverse Underwriting Decisions	x	x		
1981-16	Adverse Underwriting Decisions			x	
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

LETTER NUMBER	SUBJECT	LIFE & ANNUITIES	HEALTH	PROPERTY & CASUALTY	TITLE
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
2010-02	Online Printing of Producer Licenses	X	X	X	X



Bureau of Insurance

 Search SCC

Need to Contact Us?

Site Map

Bureau Home Page

FAQs

Contacts

Laws/Orders

Consumer

- **Special Assistance for Seniors**
 - **Consumer Guides and Lists**
 - **Important Phone Numbers and Addresses**
 - **Medicare Changes**
 - **Tax Qualified Long-Term Care Figures**
 - **New Medicare Approved Drug Discount Cards Program**
 - **Prescription Assistance Plans for Eligible Medicare Recipients**
 - **Senior Web Links**
- **Office of the Managed Care Ombudsman**
 - **Office of Independent External Appeals**
 - **Office of the Managed Care Ombudsman Brochure**
 - **10 Tips to Help You Understand Your Coverage under Your Managed Care Health Insurance Plan**
 - **Tips to Help You Appeal a Denial From Your Managed Care Health Insurance(MCHIP)**
 - **Tips to Help You Appeal a Prescription Medication Denial From Your Managed Care Health Insurance(MCHIP)**
 - **Tips to Help You Understand and Appeal Health Plan Decisions When the Coverage is Self-Insured**
 - **Consumer Assistance - Managed Care Health Insurance Plan problems and questions**
 - **View Annual Reports of the Office of the Managed Care Ombudsman**
 - **List of Bureau Consumer Guides**
 - **What are Mandated Benefits?**
 - **MCHIP Complaint System Filing Checklist**
- **Independent External Appeals**
- **Want to File a Complaint?**
- **Want Information About an Agent?**
- **Want Information About Regulated Companies?**
 - **List of Companies by Type**
 - **NAIC Consumer Information Source**
 - **National Flood Insurance Program**
 - **Workers' Compensation Loss Cost Multipliers**
- **Want a Speaker to Address Your Group?**
 - **Consumer Complaint and Outreach Service Brochure**
 - **Outreach Activities**
 - **Life and Health Consumer Outreach**

- Property and Casualty Consumer Outreach
- Speaker Request Form
- Want one of our Publications?

Producer

- Licensing Requirements & Application Fees Chart
- Downloadable Forms
- Licensing Procedures
- License Types by Classes of Insurance
- How to use the Bureau's Interactive Voice Response (IVR) System
- Administrative Letters that should be reviewed by every agent
- Common Problems Found During Agent Investigations
- Licensing FAQs
- Testing and Continuing Education
- Surplus Lines Brokers: Tax Filing Information
- Common violations of the Consumer Real Estate Settlement Protection Act (CRESPA)
- Unlicensed Ocean Marine Disclosure Form

Company

- Commercial Automobile Insurance - New Standard Forms
- Licensing Procedures
- Premium License Tax/Assessments, Tax Codes, Tax Rates & Filing Information
 - Tax, Assessment & Related Code Sites
 - Insurance Company Tax Filing Information
 - Surplus Lines Broker Tax Filing Information
 - Tax Rates
- Common Problems Found During Market Conduct Examinations
- Virginia Property and Casualty Filing Guidelines Handbook
- NAIC Financial Standard State Filing Checklists and Virginia Specific Financial and License Renewal Forms
- NAIC Product Review Standard State Filing Checklists
- Workers' Compensation Loss Cost Multipliers
- Miscellaneous Forms/Reports for Insurers
- Service of Process (SOP 19.1)

- Street Address: Tyler Building, 1300 E. Main St., Richmond, Virginia 23219
 - Mailing Address: P.O. Box 1157 Richmond, Virginia 23218
- Toll Free Phone: (Virginia Only) 1-800-552-7945 * TDD Phone: 804-371-9206
- Ombudsman and Consumer Service Hotline Toll Free Phone: (Nationwide) 1-877-310-6560
 - BOI Main Phone: 804-371-9741*Agents Licensing Phone: 804-371-9631
 - Need additional information? Contact: bureauofinsurance@scc.virginia.gov
 - Website questions? Contact: webmaster@scc.virginia.gov