Sentara Health Plans

Benefits Administrator Office Guide 2027

Mid-Market Group
More than 50 total employees and 150 or fewer eligible employees

Sentara Health Plans

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Introduction

At Sentara Health Plans, it is our privilege to partner with you in providing quality healthcare coverage to your employees. Every day, we strive to make doing business with us easier through innovative technology, streamlined processes, and exceptional customer service. Our team continually monitors the healthcare market to ensure we offer the solutions you need, especially as the economy changes. We appreciate the trust you place in us.

This Guide serves as a convenient reference for general administrative topics, including eligibility, enrollment, membership changes, primary care physician changes, continuation of coverage, and group billing.

The Sentara Health Plans website, sentarahealthplans.com, and the Sentara Health Plans mobile app also serve as valuable resources for employers and employees. Through the website and app, registered members can securely access a variety of features, including requesting member ID cards, viewing claims, checking treatment costs, and accessing benefit, health plan, and general health-related information. These resources are available 24 hours a day, 7 days a week.

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

Thank you for choosing Sentara Health Plans. We look forward to serving you and your employees in the months and years to come.

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Sentara Health Plans is a trade name of Sentara Health Plans, Sentara Health Insurance Company, Sentara Behavioral Health Services, Inc., and Sentara Health Administration, Inc. Sentara Vantage (HM0), Point of Service (POS), Direct, and Select plans are issued and underwritten by Sentara Health Plans. Sentara Plus (PPO) products are issued and underwritten by Sentara Health Insurance Company. Self-funded employer group health plans and BusinessEDGE® level-funded plans are administered, but not underwritten, by Sentara Health Administration, Inc. Stop Loss products are issued and underwritten by Sentara Health Insurance Company. All plans have benefit exclusions and limitations and terms under which the policy may be continued in force or discontinued. Wellness and rewards programs are administered by Sentara Health Administration, Inc. and are not covered benefits under any Sentara plan of our health plans. Value-added services are not covered benefits under any Sentara plan of our health plans. For costs and complete details of coverage, please call your broker or Sentara Health Plans at 1-800-745-1271 or visit sentarahealthplans.com

Mid-Market Group (over 50 total employees, 150 or fewer eligible)

Employer, employee, and dependent eligibility

Eligible employers

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

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

Eligible employees

- An employee is eligible for coverage if they:
- Are employed by the group
- Reside or work in the service area or are an out-of-area employee
- Are working regularly at least 25 hours per week
- Are at least 17 years of age
- Within 31 days of the date of initial eligibility, file a complete enrollment application, including any applicable premium or fees, with the Plan
- Do not knowingly give incorrect, incomplete, or deceptive information regarding their eligibility for coverage to the Plan or to the employer group
- Do not knowingly give incorrect, incomplete, or deceptive information regarding their dependent's eligibility for coverage to the Plan or to the employer group
- Meet any other requirements as specified herein, or as specified by the Plan or by the employer group
- Are a retiree, as long as the employer contribution is the same as full-time employees

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

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

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

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

Out-of-area employees

Employees who reside and work outside of the service area or spend more than 90 consecutive days for business purposes outside of the service area, can be included in the quote. It is recommended that the group have no more than 30% of covered employees be out-of-area employees.

The networks used for the PPO and products are the Sentara Health Insurance Company (SHIC) PPO network and a contracted national provider network outside of Virginia. The network used for the POS products is the Sentara Health Plan (SHP) network and a contracted national network outside of Virginia. Members who access care through the participating PPO or POS network providers will be eligible to receive care for covered services at the In-Network benefit level of their respective plan.

Employees NOT eligible

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

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

Eligible Dependents

- Legal spouse of the insured employee
- Domestic partner
    - Have shared a continuous committed relationship with each other for no less than 6 (six) months
    - Are jointly responsible for each other's welfare and financial obligations
    - Reside in the same household
    - Are not related by blood to a degree of kinship that would prevent marriage from being recognized under the laws of their state of residence
    - Each is over age 18, or legal age of consent in your state of legal residence, and legally competent to enter into a legal contract
    - Neither is legally married to or legally separated from, nor in a domestic partnership with, a third party
- Children up to the end of the month (EOM) in which they turn age 26. Eligible children include:
    - Natural or stepchildren
    - Foster children
    - Children placed in foster care
    - Legally adopted children
    - Children placed with subscriber for adoption

- Other children for whom the subscriber or covered spouse is a court-appointed legal guardian, including grandchildren.

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
- Marital status

The Plan will not deny or restrict eligibility of a child based on eligibility for other coverage.

Eligibility to age 26 EOM does not extend to a spouse of a child receiving dependent coverage. Eligibility to age 26 EOM does not extend to a child of a child receiving dependent coverage unless the grandparent, subscriber, or spouse becomes the legal guardian or adoptive parent of the grandchild.

Unmarried dependent children (as defined above) over age 26 EOM who are both (i) incapable of self-sustaining employment by reason of intellectual or physical disability and (ii) chiefly dependent upon the subscriber 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 an intellectual or physical disability. The Plan may require subsequent statements not more than once a year

Out-of-area dependents

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

HMO plans: Through the Out-of-Area Dependent Program, dependent children who reside outside of the Plan's service area can receive in-network benefits through the contracted national provider network. Pre-Authorization applies as necessary. Employees with dependents on an HMO plan who reside out of the service area must complete an annual certification (proof of eligibility) form prior to being eligible for the Out of Area Dependent Program and all other eligibility requirements under the Plan must be met. In-network copayments, coinsurance, and/or deductibles as listed on the Plan's Schedule of Benefits will apply.

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

Dependents NOT eligible

- Dependent children over age 26 EOM, unless incapable of self-support due to an intellectual or physical disability
- Any spouse or child who is insured as an employee of the same employer
- Grandchildren for whom the employee does not have legal custody

- Individuals no longer legally married to an eligible employee
- Dependents of an insured domestic partner for whom the employee does not have legal custody

Dependent verification

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

- Birth certificate
- Marriage certificate
- Adoption certificate or proof of placement
- Custody papers

Dependents enrolling in a Sentara Health Plans with a last name different from the last name of the subscriber may receive a letter requesting supporting documentation, as listed above. If requested, members will have 45 days to provide this documentation, or they may be dis-enrolled from the Plan.

Member Plan Changes

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

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

- Eligibility after completion of new hire waiting period
- Loss of coverage under another plan
- Reduction in hours
- Reasons defined by Section 125 guidelines
- Health Information Portable Care Act of 1996 (HIPAA) Special Enrollment Provisions

NOTE: If the group has a current Section 125 plan in place, the criteria specified in that document will apply in place of the above list.

HIPAA special enrollment provisions

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

- **Late enrollees with other coverage.** Employees or dependents who initially decline coverage because they have other group health coverage or other health insurance will be allowed to enroll late without evidence of insurability if the following three conditions are met:
    - The employee and/or dependent must be eligible under the Plan's terms;
    - When the employee declined enrollment for the employee and/or dependent, the employee stated in writing that the reason for declining enrollment was because

they 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 they declined coverage; and
    - When the employee declined enrollment for the employee and/or dependent, either the employee and/or dependent had COBRA continuation coverage under another plan and that coverage has since been exhausted; or if the other coverage was not under COBRA, either the other coverage has terminated as a result of loss of eligibility, or employer contributions toward the other coverage have terminated.
- **Effective Date of Enrollment**. Individuals must request enrollment no more than 31 days from the time that the individual knew or should have known that the other coverage has been exhausted. Late enrollment is effective no later than the first day of the calendar month beginning after the date a completed request for enrollment is received by the Plan.
- **Late enrollees** due to marriage, birth, adoption, or placement for adoption. If a dependent is added through marriage, birth, adoption, or placement for adoption, the employee and all dependents are entitled to become covered through special late enrollment. Individuals in this category do not have to have declined coverage because they had other coverage.
- **Effective Date of Enrollment.** Individuals must request coverage within 31 days of the marriage, birth, adoption, or placement for adoption. For special enrollment due to birth or adoption, late enrollment is effective on the date of the birth, adoption, or placement for adoption. For special enrollment due to marriage, late enrollment is effective no later than the first day of the calendar month beginning after the date a completed request for enrollment is received by the Plan.
- **Special enrollment** for employees and/or dependents that lose eligibility under Medicaid or CHIP coverage. Employees and/or dependents who are eligible for group coverage will be permitted to enroll late if they either lose eligibility for Medicaid or CHIP coverage or become eligible to participate in a premium-assistance program under Medicaid or CHIP.
- **Effective Date of Enrollment.** Individuals must request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

Effective date of coverage

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

- **Subscriber coverage**
    - When a person completes a written application for coverage on, or prior to, the date they satisfy the eligibility requirements above, coverage shall be effective as of the first of the month following the date eligibility requirements are satisfied.
    - When a person completes a written application for coverage after the date they satisfy the eligibility requirements above, coverage will be effective as of the first day of the calendar month following the month in which such application is received by the Plan.

- **Effective date of coverage.** Coverage under this agreement for a subscriber eligible for coverage on the initial effective date of this agreement becomes effective on the effective date of the agreement.
- **Multiple coverage**. A subscriber is not eligible to be the subscriber on more than one policy with the Plan even if they are connected with more than one participant employer. Such a subscriber will be considered as an employee of one participant employer.
- **Eligible dependents**. A subscriber's eligible dependent(s), as defined herein, are covered under this agreement only if the subscriber enrolls each dependent as a dependent. Coverage under this agreement for eligible dependents will become effective on the latter of: (i) the date the subscriber's coverage becomes effective; or (ii) on the date the subscriber acquires eligible dependents, provided notification to the Plan is within enrollment guidelines and the required premium has been paid on their behalf.
- **Newborn children.** Newborns will be covered from the moment of birth for 31 days, if the subscriber's coverage under the Plan is in effect. In order for coverage to continue beyond 31 days, the subscriber must add the newborn to their coverage within 31 days of birth. An adopted child whose placement has occurred within 31 days of birth will be considered a newborn child of the subscriber, as of the date of adoptive or parental placement. The newborn child's coverage will be identical to coverage provided to the subscriber. If the newborn is not added to the Plan within 31 days of birth, the newborn may not be eligible to enroll until the next Plan open enrollment period.
- **Adopted or foster children.** An adopted or foster child will be eligible for coverage from the date of placement with an eligible subscriber for the purpose of adoption or foster care. An adopted child whose placement has occurred within 31 days of birth will be considered a newborn child of the subscriber as of the date of adoptive or parental placement. Evidence of placement and any applicable premiums must be submitted to the Plan within 31 days from the date of placement. If the adopted or foster child is not added to the Plan within 31 days of placement the child may not be eligible to enroll until the next Plan open enrollment period.
- **Coverage mandated by court order**
    - If an employer is court ordered by a Qualified Medical Child Support Order (QMCSO) to provide healthcare coverage for a dependent, and the employee does not currently carry healthcare coverage, the Plan will allow both the employee and court-ordered dependent to enroll within 31 days of the date of the court order (with proper documentation), provided the employee has met their eligibility period.
    - The effective date may be the first of the month following receipt of the court order by the Benefits Administrator (BA), or the date the BA notified the state on the "Employer Response Page" that is returned to the state. The group must attach a copy of the Employer Response Page with the court order. If allowed to enroll in healthcare coverage, the employee must enroll the dependent.
    - If an employee is court ordered to provide medical coverage for a dependent, including a spouse, Sentara Health Plans will allow the employee and the dependent to enroll in the plan if enrollment documentation is received within 60 days of the court order date. If the enrollment request is not received timely, the employee will not be able to add the dependent until the group's next Plan open enrollment period.
- Medicare. A covered person, who is eligible to be covered under Medicare (Title XVIII of the Social Security Act of 1965, as amended), is encouraged to enroll in Parts A and B coverage on the date they are eligible. If they are under age 65, entitled to Medicare

because of End-Stage Renal Disease (ESRD), and have employer group health coverage, the covered person should contact the Plan regarding participation with Medicare Part B or assistance in obtaining Part B.

- Part-time to full-time status change. Employees whose employment status changes from part time to full time must meet the employer's eligibility waiting period before they can begin coverage.
    - If an employee is reinstated to a full-time status role within three months of moving to part-time, being laid off, and/or being terminated, they can obtain coverage on the Plan the first day of the month following the date of the status change. If an employee is reinstated to a full-time status role after three months of moving to part-time, being laid off, and/or being terminated, they are subject to the new-hire eligibility waiting period guidelines.

Policies/procedures for groups applying for coverage

Employer contribution

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

Principal ownership companies

Principal ownership companies are eligible, given the following stipulations:

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

"Class" groups

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

Mid-Market Group (over 50 total employees, 150 or fewer eligible)

Sentara Health Plans 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 Sentara Health Plans. Employers must consult with their legal and tax advisors on this matter. Employers that discriminate in their healthcare plans may be subject to financial and tax penalties.

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

Waiting periods/contributions

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 SHP or SHIC, 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.

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

Probationary/orientation periods

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

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

Participation requirements

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

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

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

Groups with valid waivers that leave only one enrolling employee will be allowed to enroll and/or renew their health coverage.

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

Employer group health questionnaire

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

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

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

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

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

Waivers

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

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

- Reason for waiver

Carrier and policy of other insurance if reason for waiver is other insurance (Sentara Health Plans reserves the right to verify other insurance coverage)

Virginia Employment Commission Quarterly Wage and Earnings Report

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

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

- Full time (FT)
- Part time (PT)
- Cot eligible (NE)—Please note class of ineligibility: part time less than 30 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 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 1120s)
- 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, gender, or level/tier of coverage of any insured employee has been misstated, the member's correct age, gender, or level/tier of coverage shall determine the amount payable under the group policy. All premiums due as a result of such misstatement will be adjusted and reflected on the group bill. Documentation may be required to validate corrections to previously stated information.

Mid-Market Group (over 50 total employees, 150 or fewer eligible)

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 first month's premium will be due no later than the end of the month that the first month's invoice is generated. If an initial payment is returned for non-sufficient funds (NSF) or any other reason, coverage may be terminated as of the original effective date.

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

Work-related illness and/or injury

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

Guidelines/policies/procedures

Mid-Market group new business

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

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

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

Items required to complete the enrollment process include:

- Employer Group Application
    - Sentara Health Plans Employee Application
    - Waivers for eligible employees who are not electing coverage
- A VEC, declaration letter, or other required eligibility documentation may be required to confirm the group size for segment determination

Risk acceptance

SHP and SHIC 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, may result in the termination of coverage if, in the sole judgment of SHP or SHIC, the omitted information was material to the person(s)' or group's eligibility or insurability.

Any information obtained regarding the group's compliance with new or renewing group caveats will be investigated as necessary. Non-compliance with said caveats, whether intentional or unintentional, will result in the termination of coverage if, in the sole judgment of SHP or SHIC, 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 SHP or SHIC 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.

SHP and SHIC may terminate coverage for:

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

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

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

Additional underwriting requirements/information

Groups may offer up to four plans.

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

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.

Mid-Market Group (over 50 total employees, 150 or fewer eligible)

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

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

Membership changes

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

- All changes must be submitted within 60 days of new-hire eligibility or a HIPAA Special Enrollment Provision (qualifying life event).
- Requests to add a new employee or to add a spouse and/or dependent(s) to an existing employee's coverage must be submitted on a Sentara Health Plans Employee Application/Health Questionnaire. Applications/Health Questionnaires must be complete and accurate. Applications to add newborns or adopted children must be received within 31 days from the date of birth or placement. Documentation must be provided to show the date of birth or adoption.
- The Application/Health Questionnaire must be signed by the applicant and submitted within 30 days of the requested effective date.
- Membership additions/changes that are submitted within 90 days of the group's initial effective or renewal date may require the group to be resubmitted to underwriting for re-evaluation and rate adjustment.
- In the event that enrollment changes increase or decrease the group's existing census by 15% or more, the group will be subject to underwriting review and may be re-rated for a new contract period using the most current rates available.

Retroactive disenrollment

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

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

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

Coverage cannot be terminated retroactively if the employee or member was allowed to continue coverage and incurred claims after termination of employment or eligibility, and the employee or member paid premium or contributed to the cost of coverage after termination of

employment or eligibility. In these cases, Sentara Health Plans 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 Sentara Health Plans, the group must ensure that employees and dependents did not pay premiums/contributions during the retroactive-termination time period. When retroactive terminations are submitted, Sentara Health Plans will regard the submission as verification that no premium/contribution was paid by the member/dependent for that period.

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

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

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

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

Plan changes

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

- Requests for proposal for off-cycle changes must be received by Sentara Health Plans, in writing from the company or the agent/broker, at least 75 days prior to the requested effective date.
- A final decision on any potential change–including exact plan designs to be offered and any required supporting documentation—must be received by Sentara Health Plans at least 65 days in advance of the proposed effective date. Please note that if day 65 falls on a weekend or holiday, Sentara Health Plans will need the decision by the last business day beforehand.
- Upon receipt of the final decision, the Sentara Health Plans Account Executive will forward via email the appropriate new Summary of Benefits and Coverage (SBC) document(s), for distribution by the group to its employees 60 days prior to the change effective date.
- Please allow no less than five business days for the completion of plan change requests.

- Any group making an off-cycle change will receive a new contract year/effective date using current quarter rates. All member deductible and maximum out-of-pocket accumulators will reset with the new effective date.
- If groups do not meet these timelines, they will have to wait until the following month to make their benefit change.

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

Premium payments

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

Reinstatement of groups terminated for non-payment of premium

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

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

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

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

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

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

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

Renewal proposals

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

Mid-Market Group (over 50 total employees, 150 or fewer eligible)

Groups receiving a 35% or greater premium increase must receive their renewal rates at least 60 days prior to their anniversary date. Groups receiving less than a 35% premium increase must receive their rates at least 31 days prior to their anniversary date.

The AOR/BOR is required to notify their SHP or SHIC 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, SHP or SHIC 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.

Contacts

Online and Mobile

Sign in to sentarahealthplans.com/members or the mobile app to use live chat or email. You will need to register your account to access your secure member information as well as special tools available only to Sentara Health Plans members. The mobile app can be downloaded from the App Store or Google Play.

Email members@sentara.com

Please note: *To protect your privacy, we may not be able to provide all information via email. Members who register and sign in to sentarahealthplans.com can contact member services securely using the Contact Us form.*

Mail
Sentara Health Plans Member Services
PO Box 66189
Virginia Beach, VA 23466

Member Services
1-800-275-3755
Office hours: Monday–Friday, 8 a.m. to 6 p.m.
After normal business hours, please leave a message.

For the fastest service, have your member ID card available when you call.

Nurse Advice Line
1-800-394-2237 or 757-552-7250
Available 24 hours a day, 7 days a week

This does not replace contacting your doctor during regular office hours. The Nurse Advice Line can answer injury or illness questions when your doctor's office is closed.

TDD/TYY lines for the hearing-impaired
711 or 1-800-828-1140

Language services for non-English speaking members
Call 1-855-687-6260 to access language services.

Behavioral Health Services
1-800-648-8420 or 757-552-7174

Frequently asked questions

How do I register on sentarahealthplans.com and the Sentara Health Plans mobile app?
Covered members age 18 or older can register for an online account at sentarahealthplans.com or through the Sentara Health Plans mobile app. To register, you'll need your member ID card.

Once registered and signed in, you can:

- View and email digital member ID cards
- Access claims information and authorizations
- Schedule virtual consults
- View coverage and benefit details, including deductibles, and balances
- Find doctors, facilities, and urgent care centers near you
- Get healthy with free wellness tools from WebMD® Health Services
- Look up costs for treatments, surgeries, and other services
- Access health records including test results, medications, immunizations, health conditions
- View, price, and refill prescriptions
- Set communications preferences—paperless and Spanish language options available for most materials
- Access HSA or HRA accounts
- Download common forms and documents
- View detailed EOB with complete cost breakdown and access Sentara Bill Pay

What do I do if I forget my password or username?
If you forget your username, select *Forgot Username* on the sign-in page. Enter the requested information and select *Submit*. Your username will be sent to the email address on file.

If you forget your password, select *Forgot Password* on the sign-in page. Enter your username and select *Submit*. A password reset email will be sent to the email address on file.
If you enter an incorrect password too many times and become locked out of your account, select *Forgot Password* to reset it.

If you are unable to recover your username or password using these options, contact Member Services at the number on the back of your member ID card for assistance.

What do I do if I have questions about the information I see on sentarahealthplans.com or the mobile app?
Contact member services at the number on the back of your member ID card or online through our "Contact Us" form.

How do I know my information is safe/secure?
We are required by law to:

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

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

Can I view my dependent's claims and other benefit information?
You can view and perform certain self-service functions for covered dependents under age 14, including viewing claims, viewing referrals and authorizations, updating contact information, and viewing benefit summaries.

For dependents age 14 and older, the dependent must grant access before you can view their information. To grant access, the dependent must register and sign in to their account.

How to grant access:

- For general benefit information and medical claims, the dependent can select the check boxes for *View Claims* and *View Referrals/Authorizations*.
- For pharmacy claims, the dependent can go to *Pharmacy Resources* and then select *Manage Family Access* in the Express Scripts (ESI) portal.

The access option will appear the next time you sign in. Access can be granted or removed at any time.

How do I allow my spouse to view my claims?
To grant your spouse access to your claims and benefit information, you must register for and sign in to your account. Once signed in, follow the steps above to grant access. You can grant or remove spouse access at any time.

How do I know if my prescription drug is covered?
You can search our Prescription Drug Lists and Formularies or online search tool. Covered members may also sign in to determine coverage and exact copayment amount using the "Pharmacy Resources" link located on the left-hand menu.

Where do I find benefit information?
Sign in to sentarahealthplans.com or the mobile app to view your Benefit Summary and Uniform Summary of Benefits and Coverage documents.

Sentara Health Plans
PO Box 66189
Virginia Beach, VA 23466
757-552-7217
1-866-927-4785 (Toll-free Virginia Statewide)

sentarahealthplans.com