2025

Benefits Administrator Office Guide

Business*EDGE*®
5-250 Total Employees

Sentara® Health Plans

Sentara®
Health Plans

Benefit Administrator Office Guide

Business*EDGE*® (5–250 Enrolled Employees)

January 2025

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Introduction

At Sentara Health Plans it is our privilege to partner with you to provide quality healthcare to your employees. Each day we strive to make it easier to do business with us through new technologies and simplified processes, while never losing sight of exemplary customer service. Our team focuses on the market to ensure we continue to offer the best healthcare solutions, especially as the economy changes. We appreciate the trust you place in us.

This Guide serves as a convenient reference on general administrative topics such as eligibility, enrollment, membership changes, primary care physician changes, continuing coverage, and group billing.

The Sentara Health Plans website, sentarahealthplans.com, and the Sentara Health Plans mobile app also serve as valuable resources for employers and employees. Both the app and the website allow registered members to perform a number of secure transactions within the health plan, including the ability to request member ID cards, view claims, and look up treatment costs in addition to benefit, health plan, and general health-related information. You may visit the website 24 hours a day, 7 days a week.

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

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

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Business*EDGE*® (5–250 enrolling employees)

Segment Determination for Fully Insured Groups

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

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

Employers, employee, and dependent eligibility

Eligible employers

- Corporations, partnerships, or sole proprietorships with a clear employer/employee relationship (1099 employee relationships and disabled workers are not eligible for group coverage).
- For Business***EDGE***: financially stable business organizations with 5–250 total employees (including owners and partners) and has 5–250 enrolling employees; employers/companies who have not declared bankruptcy or exited bankruptcy in the last five years.
- Employers with a payroll-deduction system established for employee contributions.
- Groups that file a Virginia Employment Commission (VEC) Quarterly Wage and Earnings Reports.
- Employer groups not formed for the sole purpose of securing insurance.
- Employer groups located within the Sentara Health Plans service area.
- Employer groups that have been in business for at least one year.
- Carve-outs may be allowed and are subject to nondiscrimination rules and policies.

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.

An employer group who would otherwise be eligible for coverage under Sentara Health Plans may nonetheless be ineligible if offering coverage to that employer group would 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 employees

An employee is eligible for coverage if they:

- Are employed by the group.
- Reside or work in the service area or is an out-of-area employee (and no more than 35% of the eligible and enrolled employees are out-of-area).

- Are at least 17 years of age, work at least 30 hours per week, and work and receive a salary for 50 weeks or more per year.
- Are a U.S. citizen who possesses a Social Security number.
- Are a legal alien who has possession of a green card as well as a Social Security number.
- Are within 31 days of the date of initial eligibility and 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 or health history to the Plan or to the employer group.
- Do not knowingly give incorrect, incomplete, or deceptive information regarding their dependent's eligibility for coverage or health history 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

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

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

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

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

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

Out-of-area employees

Employees who reside and work outside of the service area or spend more than 90 consecutive days for business purposes outside of the service area, can be included in the quote. No more than 35% of the covered employees can be covered who reside and work outside of the service area. If more than 35% of the group's covered employees are outside of the service area, the

group will either be quoted without the OOA employees or Sentara Health Plans will be unable to provide a quote for the entire group.

The networks used for the PPO products, which provide access to in-network providers, are the SHIC PPO network and a contracted national provider network. The networks used for the POS products, which provide access to in-network providers, are the SHP network and a contracted national provider network. Members who access care through the participating PPO or POS network providers will be eligible to receive care for covered services at the **i**n-**n**etwork 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
- Retirees or pensioned 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 the 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 network POS with a contracted national provider network. Dependents and spouses who access care through the participating PPO network providers 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
- Any spouse or children for whom the employee has waived coverage

Dependent verification

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

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

Dependents enrolling in 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 (qualifying life Events)

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

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

The Plan provides special enrollment periods of 30 days from the date of a triggering event for qualified employees or dependents who:

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

Effective date of coverage

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

- **Effective date of coverage.** Coverage under this agreement for a subscriber eligible for coverage on the initial effective date of this agreement becomes effective on the effective date of the agreement.
- **Multiple coverage.** A subscriber is not eligible to be the subscriber on more than one policy with the Plan even if 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.
- **Subscriber coverage—addition to an in-force plan**
    - When a person completes an Employee Enrollment 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 an Employee Enrollment 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.

- **Newborn children.** Newborns will be covered from the moment of birth for 30 days, if the subscriber's coverage under the Plan is in effect. In order for coverage to continue beyond 30 days, the subscriber must add the newborn to their coverage within 30 days of birth. An adopted child whose placement has occurred within 30 days of birth will be considered a newborn child of the subscriber, as of the date of adoptive or parental placement. If the newborn is not added to the Plan within 30 days of birth, the newborn may not be eligible to enroll until the next Plan open enrollment period.
- **Adopted or foster children.** An adopted or foster child will be eligible for coverage from the date of placement with an eligible subscriber for the purpose of adoption or foster care. An adopted child whose placement has occurred within 30 days of birth will be considered a newborn child of the subscriber as of the date of adoptive or parental placement. Evidence of placement and any applicable premiums must be submitted to the Plan within 30 days from the date of placement. If the adopted or foster child is not added to the Plan within 30 days of placement the child may not be eligible to enroll until the next Plan open enrollment period.
- **Coverage mandated by court order.**
    - If an employer is court ordered by a Qualified Medical Child Support Order (QMCSO) to provide healthcare coverage for a dependent, and the employee does not currently carry healthcare coverage, the Plan will allow both the employee and court-ordered dependent to enroll within 30 days of the date of the court order (with proper documentation), provided the employee has met their eligibility period.
    - The effective date may be the first of the month following receipt of the court order by the Plan Administrator, or the date the Plan Administrator notified the state on the "Employer Response Page" that is returned to the state. The group must attach a copy of the Employer Response Page with the court order. If allowed to enroll in healthcare coverage, the employee must enroll the dependent.
    - If an employee is court-ordered to provide medical coverage for a dependent, including a spouse, Sentara Health Plans will allow the employee and the dependent to enroll in the plan if enrollment documentation is received within 30 days of the court order date. If the enrollment request is not received timely, the employee will not be able to add the dependent until the group's next Plan open enrollment period.
- **Medicare.** A covered person, who is eligible to be covered under Medicare (Title XVIII of the Social Security Act of 1965, as amended), is encouraged to enroll in Parts A and B coverage on the date they are eligible. If 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.** Coverage of employees whose employment status changes from part-time to full-time is effective on the first day of the month following the date of the status change, provided any eligibility waiting period has expired. The eligibility waiting period begins on the employee's first day they move from part-time to full-time status.
    - If an employee is reinstated to a full-time status role within three months of moving to part-time, being laid off, and/or being terminated, 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 employee premium. It must be fair, equitable, and non-discriminatory toward any employee class.

Principal ownership companies

Principal ownership companies are eligible, given the following stipulations:

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

Group waiting periods

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

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

Participation requirements

Groups are required to have 70% participation of eligible employees and no less than 5 enrolling employees. Employees who waive coverage to stay on another qualifying plan (such as Medicare, TRICARE/CHAMPUS, or a spouse's employer-sponsored plan) are not considered eligible employees for the purpose of the participation calculation and will not count against the group's participation. To determine group participation:

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

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

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

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

Employee enrollment

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

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

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

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

Waivers

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

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

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

Virginia Employment Commission Quarterly Wage and Earnings Report

Along with the completed Employer Group Application and Individual Employee Application, groups applying for coverage must also supply a copy of the group's most recent Virginia Employment Commission (VEC) Quarterly Wage and Earnings Report.

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

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

Changes/deletions made on the actual VEC report should be signed and dated by an authorized representative of the group.

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

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

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

Misstatement of age or class

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

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

Premium check/payments

The initial payment needs to be submitted using the required ACH form. All monthly payments after that will be debited from the same account used to set up the Business***EDGE*** contract unless arrangements are made with Finance to update the payment source. If an initial payment is denied for non-sufficient funds (NSF) or any other reason, coverage may be terminated as of the original effective date.

Work-related illness and/or injury

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

Stop-loss insurance

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

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

Stop-loss advancements

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

aggregate claims throughout the contract year, provided monthly payments are paid in full to date. If the group terminates the contract early, they are responsible for repaying the advancements.

Run-out period

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

The run-out period for the Business***EDGE*** contract will be 12 months after the end of the contract period. After the 12-month run-out period, if the group is still insured with Sentara Health Plans and actual claims history is lower than predicted, the group can collect a refund. The refund percentage of the unused claims fund is determined at the time the group is initially set up.

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

Guidelines/policies/procedures

Business*EDGE* new business

Employer groups for Business***EDGE*** must have 5–250 enrolling employees.

All enrollment forms should be completed and received by Sentara Health Plans 10 days prior to their requested effective date of coverage.

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

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

Initial risk assessment

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

Sentara Health Plans has the right to revise the rates (retrospectively or prospectively) for the Stop-Loss Insurance Contract, or rescind or terminate the Stop-Loss Insurance Contract if a person completes the Employee Statement, Employee Application, Employee Enrollment Form, or other similar form (collectively “Form”) with false, incomplete, or misleading information; or fails to notify Sentara Health Plans of any changes to the answers to the medical information

question in any Form resulting in a material misrepresentation affecting the assessment of the risk or the terms or conditions for coverage.

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

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

Installation of group

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

Enrollment process

Business***EDGE*** groups may have an open enrollment period up until the fifteenth of the month prior to the group's effective date. Any employee who does not submit an application to Sentara Health Plans by that date will need to wait until the group's next open enrollment period to apply for coverage, unless there is a qualifying event. Any employee who does submit an application prior to the fifteenth of the month prior to the group's effective date (that will change the quoted census) may subject the group to underwriting review and re-underwriting.

If a group wants to complete its open enrollment prior to the fifteenth and submit all enrollment material, Sentara Health Plans will accept the enrollment and the same guidelines (mentioned above with regards to qualifying event or not) apply to applications that come in after the enrollment submission date.

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

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

Items required to complete the enrollment process include:

- The most current version of the Group Application for Employer Stop-Loss Insurance
- Complete Employee Applications for every employee who is applying for coverage or Enrollment Spreadsheet with all enrolling employees. All employees who are in their waiting period and are eligible for coverage within 90 days of the group's effective date should also complete an Employee Application. Applications must be signed and dated by applicant and plan administrator. **NOTE:** Any applications signed more than 90 days prior to the effective date will require a new, updated application. Any application submitted after the offer has been accepted could require the group to be re-underwritten, causing the group to be charged the appropriate premium as of the original effective date of the group.
- A complete group census form

- Waivers for eligible employees who are not electing coverage
- Prior carrier bill
- VEC, declaration letter, or other required eligibility documentation
- Binder Check (or Binder Check ACH)
- ACH (w/ voided check)

Failure to disclose

Any information obtained regarding the group's compliance (or non-compliance) with new or renewing group caveats will be investigated as necessary. Non-compliance with said caveats, whether intentional

or unintentional, will result in the termination of coverage if, in the sole judgment of Sentara Health Plans, 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.

Prior SHP or SHIC group coverage

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

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

Termination of coverage

If coverage is terminated prior to contract end date, the stop loss policies are also terminated, and claims will no longer be processed. All payments made to Sentara Health Plans will be retained by Sentara Health Plans.

Sentara Health Plans may terminate coverage for:

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

Additional requirements/information

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

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

Acceptance

After Sentara Health Plans has received the group’s acceptance, the following documents will need to be provided to the employer:

- Employer Contract
- Employee Applications or Enrollment Spreadsheet
- Waivers
- VEC
- Binder Check (or Binder Check ACH form)
- ACH (w/ voided check)

These documents need to be signed and dated by the employer and returned to Sentara Health Plans prior to the coverage effective date.

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 Enrollment Application. Applications must be complete and accurate. Applications to add newborns or adopted children must be received within 30 days from the date of birth or placement. Documentation must be provided to show the date of birth or adoption.
- The Employee Enrollment Application must be signed by the applicant and submitted within 31 days of the requested effective date.

Retroactive disenrollment

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

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

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

Coverage cannot be terminated retroactively if the employee or member was allowed to continue coverage and incurred claims after termination of employment or eligibility, and the employee or member paid premium or contributed to the cost of coverage after termination of employment or eligibility. In these cases, 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 employer 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 Sentara Health Plans 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 Plans will authorize a retro-termination date of November 30, and a credit for billed and paid premiums should occur on the group's next billing cycle.

If notification is received in February for a requested termination date of November 30 and the member has made no premium contribution, and no claims have been incurred, 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 Affordable Care Act (ACA) and all state Health Reform conditions for retroactive termination of coverage have been met. The Plan may examine the group's records relating to the coverage under this agreement during normal business hours at a location mutually agreeable to the group and the Plan. ACA means the Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and as it may be further amended.

Group plan changes

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

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

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

- Newly completed Group Application for Stop-Loss
- Newly completed member application for any and all employees being added to the plan

- Most recent State Quarterly Wage and Tax Statement (this may be required at the discretion of the underwriter)
- Group employee census

Monthly payment amounts

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

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

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

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

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

Rate guarantee

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

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

- Changes or more than 15% in the composition for covered employees
- Any addition of a subsidiary, locality, a new startup company, or a new group class of employees coming onto its plan
- The business is no longer in the same type of business/trade as when the plan was originally effective
- Any changes made to the plan's benefits
- Any changes in the federal or state laws which could affect any covered employees. Sentara Health Plans has the right to make changes to the rates on any due date following the group's effective date of any state premium tax law or change to such law. This change and amount will be determined by the amount imposed by the new tax law.

Surplus refund

Any group surplus will be determined in the thirteenth month after the end of the contract year. The group will be eligible to receive the surplus refund only if the group is still insured by any Sentara Health Plans group plan at the time of the surplus determination.

Renewal proposals

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

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

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

Annual open enrollment period

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

Employee contacts at a glance

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

Online and mobile
Visit sentarahealthplans.com or the Sentara Health Plans mobile app to:

- Access MDLIVE® virtual visits.
- View a list of Plan providers.
- Change your Plan primary care physician (PCP).
- Update your home address, phone number, or email address.
- View and order a member ID card.
- View your claims history.
- View your benefits.
- View your authorizations.
- View deductible and maximum out-of-pocket accumulators.
- View member guide.
- Download member forms.
- Learn about member discounts.
- Manage your pharmacy benefit (if administered by Sentara Health Plans).
- Research drug options and pricing.
- Choose to receive your Explanation of Benefits (EOB) electronically.
- Research conditions, treatment options, and hospital quality.
- Find costs for all covered treatments and services.
- Contact member services.

You will need to register on sentarahealthplans.com or the mobile app 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. For the most up-to-date customer service numbers, please refer to the numbers located on the back of your Member ID card.*

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

Member services
1-877-552-7401 or 757-552-7401
Office hours: Monday–Friday, 8:00 a.m. to 6:00 p.m.
After normal business hours, please leave a message.

After Hours Nurse Advice Line
The After Hours Nurse Advice Line can be reached 24 hours a day at 1-800-394-2237 or 757-552-7250. This does not replace contacting your doctor during regular office hours. The After Hours Nurse Advice Line can answer injury or illness questions when your doctor's office is closed.

TDD/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

Employee frequently asked questions (FAQs)

How do I register on sentarahealthplans.com and the Sentara Health Plans mobile app?
A covered member on the health plan, aged 18 or older, can go to the registration page on sentarahealthplans.com. A member ID card is needed when registering.

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

What do I do if I have questions about the information, I see on 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.

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

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

How can I access my child's pharmacy claims?
Currently members are only able to access their specific pharmacy claim information. We are working to allow members to view covered dependents in the future.

How do I know if my prescription drug is covered?
You can search our drug lists using the Drug Search Tool. Covered Members may also sign in to determine coverage and exact Copayment amount using the “Pharmacy Resources” link located on the left-hand 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