Sentara Health Plans

Benefits Administrator Office Guide 2027

Small Group
1-50 total 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

Employer, employee, and dependent eligibility

Eligible employers

- Corporations and partnerships with a clear employer/employee relationship, self-employed individuals, or sole proprietorships
- Organizations with at least one eligible employee (includes owners and partners; excludes COBRA participants), but not more than 50 total employees
- Employer groups not formed for the sole purpose of securing insurance
- Employer groups located within the 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 public/private exchange may be exempted.

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).
- Work at least 30 hours per week.
- Part-time employees working less than 30 hours per week are eligible employees at the employer's discretion.
- Are at least 17 years of age.
- Are 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.

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.
Directors or partners of a company are not excluded, provided they meet the criteria listed above. Sole proprietors, directors, partners, principals for any two-person group, or any other

group not required or able to submit a VEC Quarterly Wage and Earnings Report will be required to submit at least 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

Self-employed individuals

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

- Operated by the individual as a sole proprietor
- Through which the individual has attempted to earn taxable income
- For which the individual has filed the appropriate Internal Revenue Service Form 1040, Schedule C, E, or F, for the previous taxable year

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

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

Self-employed or any other group not required or able to submit a VEC Quarterly Wage and Earnings Report will be required to submit at least one of the following:

- Declaration letter attesting that they meet the above-listed criteria
- List of all current employees and social security numbers
- Copy of the business license
- Papers of incorporation listing principals/officers of the company
- Partnership agreement
- Payroll summary

Additional documentation required:

- C Corporation: most recently filed W2 form or VEC

- Sole Proprietor: IRS 1040 Schedule C, E, or F
- Partnership, S Corporation, or LLC: most recently filed IRS Schedule K1 (Form 1065 or 1120s)

1099 employees

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

The following criteria must be met:

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

Spousal partners

A group with spousal partners, where both are owners of the corporation or both are partners in an LLC, is eligible for small group coverage.

If the group is unable to submit a VEC Quarterly Wage and Earnings Report, they will be required to submit at least one 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
- Payroll summary

Additional documentation required:

- C Corporation: most recently filed W2 form or VEC
- Partnership, S Corporation, or LLC: most recently filed IRS Schedule K1 (Form 1065 or 1120s)

Employees NOT eligible

- Independent contractors (1099) of the employer, except as noted in the above section
- Employees who work less than the minimum hours required by the employer
- Leased, temporary, or seasonal employees unless they meet the criteria for coverage as a 1099 employee
- Directors and officers not otherwise eligible as active, full-time employees
- Retirees or pensioned employees

A person who would otherwise be eligible for coverage may nonetheless be ineligible if that person could cause 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.

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 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.

Eligible dependents

- An Employee's lawful spouse;
- 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 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 the 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 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 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 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 the 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 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 60 days from the date of a triggering event for qualified employees or dependents who:

- Become eligible for assistance with respect to coverage under a Medicaid or CHIP plan (including any waiver or demonstration project conducted under such plan).
- Lose eligibility under Medicaid or CHIP coverage. The employer is required to provide employees notice of special enrollment rights and premium assistance under CHIP. In both cases the employee must request special enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

Effective date of coverage

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

- **Subscriber coverage**
  - When a person completes a written application for coverage on, or prior to, the date 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. 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. 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**. 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

There is no minimum employer contribution level in small group.

Principal ownership companies

Principal ownership companies are eligible, given the following stipulations:

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

Group waiting periods

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 Sentara Health Plans (SHP) or Sentara Health Insurance Company (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.**

Class-based waiting periods/employer contributions

Groups may elect to have different new hire waiting periods and/or employer contributions for different classes. The effective day must be the first day of the month. 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 are required to have 70% participation of eligible employees. Employees who waive coverage to stay on another qualifying plan (such as Medicare, TRICARE/CHAMPUS, or a spouse's employer-sponsored plan) are not considered eligible employees for the purpose of the participation calculation and will not count against the group's participation. To determine group participation:

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

Participation of 70% would require that 14 of the 20 potential enrolling employees participate in the Plan. Participation is a continuing requirement. Participation requirements must be met at the time the group is underwritten, and throughout enrollment under the Plan(s). Failure to maintain required participation levels may result in termination of the group at any time the participation falls below the required level. Renewal of a group may be contingent upon re-verification of the group's employee participation.

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

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

Employee application

New groups may either submit individual applications or use the Sentara Health Plans spreadsheet enrollment tool. If using applications, they must be completed and signed by the employee. When requesting coverage for dependents, their enrollment must also be provided.

NOTE: All sections of the application must be completed prior to submission. Incomplete applications may be returned to the employee for completion and may delay the enrollment process.

Each employee in a current group applying for coverage must complete an Employee Application. The application must be completed and signed by the employee and BA. When requesting coverage for dependents, their enrollment must also be provided.

NOTE: All sections of the application must be completed prior to submission. Incomplete applications may be returned to the employee for completion and may delay the enrollment process.

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

Employees who decline coverage for any reason and later decide they want to apply for coverage will be able to do so at the next open enrollment opportunity or if a qualifying event qualifies the employee for a Special Enrollment.

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

Waivers

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

- Self, which will include all dependents
- Spouse only
- Child or children only
- Spouse and child or children
- 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 Individual Employee Application, 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 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 30 hours, in new-hire waiting period, active duty
- Terminated (T) (must provide date of termination)
- Waiving coverage (W) (waiver section of application must be completed)

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

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

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

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

Premium check/payments

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

Employers with three or more employees (full-time and/or part-time) are required to maintain a Workers' Compensation policy. Work-related illness/injury claims incurred by employees of an

employer group of three or more employees will not be covered under their group health plan. This will apply to all employees, owners, directors, and/or officers of the company. Sentara Health Plans may require that the group provide the Workers' Compensation carrier name and policy number.

Guidelines/policies/procedures

Small Group new business

Small Group is considered to be employer groups with 1–50 total employees. The total employee count includes all full-time and part-time employees.

Please allow no less than five business days for the completion of enrollment. Return of incomplete applications to the group/employee may also cause delays in the enrollment process. Please ensure that the correct application has been used based on the segment (size) of the group and the applicable product, and that all areas on the application are complete prior to submission to avoid unnecessary delays.

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

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

Items required to complete the enrollment process include:

- Employer group application
- Complete employee enrollment. Individual applications must be signed and dated by applicant. **NOTE:** Any application signed more than 90 days prior to the effective date will require a new, updated application.
- Waivers for eligible employees who are not electing coverage
- VEC, declaration letter, or other required eligibility documentation

ACA age or composite rates for new business cases

The ACA now allows for composite rating in the small group segment. Groups may choose between one-year age-banded rates or composite rates. The default approach will be age-banded rates. If the customer wants composite rates, this should be confirmed in writing by either of these methods:

- Email confirmation
- A note on the Group App for new business

Risk acceptance

SHP and SHIC approval of coverage for eligible employees or dependents is subject to the completeness and accuracy of the Employee Application and the Employer Group Application.

Omission of information on the Employee Application or the Employer Group Application, whether intentional or unintentional, will result in the termination of coverage if, in the sole judgment of 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 the 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 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

Additional requirements/information

Groups may offer up to three plans.

Companies originally written as a Small Group (1–50 total employees) that increase their total employee count to 51 or more employees during the contract year will remain Small Group until renewal. At renewal, such groups will be reviewed on a case-by-case basis to determine their status. The same review will apply to groups that fall below 51 total employees during the contract year.

If an existing group splits for any reason, (for example, a change in ownership or sale of division), then all formed companies of the group will be issued a new 12-month contract period using the current quarter's rates. Additional documentation may be requested, such as waivers and/or applications, from any employee not currently enrolled in the group's plan.

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

If a current Sentara Health Plans Small Group merges with or acquires another small group (assuming the two together do not exceed the Small Group segment size requirements) and the current Sentara Health Plans group wants to add the newly acquired employees to their current health coverage immediately, they may waive the waiting period for those newly acquired employees only.

Retroactive dis-enrollment

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

Plan changes

Plan changes should be done at the time of renewal. However, 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 in order 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 re-enrollment.

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

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

Renewal proposals

Proposals for renewing groups will be prepared and forwarded to the current Agent or Broker of Record (AOR/BOR) approximately 90 days prior to the group's renewal date. Groups will be notified approximately 31 days prior to their effective date that their renewal information has been forwarded to the AOR/BOR. Complete proposals are not forwarded to the group directly; administrators will receive only the notification of renewal and the proposed renewal rates. It is the responsibility of the current AOR/BOR to deliver and review the proposed rates, benefits, and plan changes promptly to the group.

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

ACA age or composite rates

The ACA allows for composite rating in the Small Group segment. Groups may choose between one-year age-banded rates or composite rates. The default approach will be age-banded rates. If the customer wants composite rates, this should be confirmed in writing by either of these methods:

- Email confirmation
- Notation on the Group Information Summary for existing business

If census changes between the quote date and the plan effective date such that premium changes by 10% or more, the composite rates may be re-calculated using the new census.

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