2026

Benefits Administrator Office Guide

Large Group
151+ eligible employees

Sentara® Health Plans

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.

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

sentarahealthplans.com

Large Group (151+ eligible)

Employers, employee, and dependent eligibility

Eligible employers

- Corporations or partnerships with a clear employer/employee relationship with 151 or more eligible employees.
    - To calculate eligible employees, including owners and partners but exclude COBRA participants (who are eligible for coverage but not counted to determine Large Group eligibility).

Eligible employees

- An employee is eligible for coverage if they:
- Are employed by the group
- Are at least 17 years of age
- Are working regularly at least 30 hours per week, 50 weeks per year
- Are within 31 days of the effective date of coverage, 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 by the Plan or by the employer group (such as early- and Medicare-eligible retirees or pensioned employee)

Retired employees may be eligible depending on the group's criteria and history. An additional premium may be associated with this eligible class.

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

Note: For current groups, the employees must meet the new hire waiting period established by the employer. New groups can waive the new hire waiting period at the time of the Group's initial enrollment with SHP or SHIC, but only if they do so for all of the employees. After initial enrollment, the new hire waiting period can only be changed at renewal.

Out-of-area employees

Employees who reside 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.

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.

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, or leased, temporary, or seasonal employees
- Directors, board members, and officers not otherwise eligible as active, full-time employees
- Eligible dependents
- Legal spouse of the insured employee
- Children up to the end of the month (EOM) or end of year (EOY) in which they turn age 26, depending on what is requested and underwritten. 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/EOY based on any of the following:

- Financial dependency on the subscriber or any other person
- Residency with the subscriber or any other person
- Student status
- Employment status
- Marital status

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

Eligibility to age 26 EOM/EOY does not extend to a spouse of a child receiving dependent coverage. Eligibility to age 26 EOM/EOY does not extend to a child of a child receiving dependent coverage unless 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/EOY who are both (i) incapable of self-sustaining employment by reason of an 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.

Domestic partners may be eligible depending on the group's criteria and history. An additional premium may be associated with the addition of this eligible class.

Out-of-area dependents

PPO and POS plans: The networks used for the PPO and POS products, which provide access to in-network providers, are the SHIC PPO network or SHP POS network with a contracted national provider network. Dependents and spouses who access care through the participating

PPO 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/EOY, unless incapable of self-support due to an intellectual or physical disability (dependent age limits may be modified to cover children older than 26 EOM/EOY upon group request and underwriting approval at initial enrollment or prior to annual renewal)
- Any spouse or child who is insured as an employee of the same employer
- Grandchildren for whom the employee does not have legal custody
- Individuals no longer legally married to an eligible employee

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

Employees with dependents on an HMO plan who reside out of the service area must complete an annual proof of eligibility form to receive in-network benefits from contracted national providers.

The Plan reserves the right to request or review at any time, at its sole and absolute discretion, proof of eligibility of any subscriber or dependent enrolled in the Plan. Should the Plan discover at any time that any subscriber or dependent is not eligible for coverage, was never eligible to be enrolled for coverage, and/or submitted false proof of eligibility for coverage, the Plan may, at its sole discretion, either refund all or part of the premium payment made on behalf of the subscriber/dependent to the group and retract all or part of any claims paid from the provider(s), or retain the premium paid on behalf of the ineligible subscriber/dependent up until the date the Plan became aware of the ineligibility and cancel the subscriber's/dependent's coverage after the date through which premiums were paid. Dis-enrollment of a subscriber or dependent due to ineligibility for coverage may result in the reversal and/or denial of claims during the period of ineligibility. The subscriber/dependent may be held responsible for any charges for claims for services during the period of ineligibility.

HIPAA special enrollment provisions

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

- **Late enrollees with other coverage.** Employees or dependents who initially decline coverage because they have other group health coverage or other health insurance, will be allowed to enroll late without evidence of insurability if the following three conditions are met:
    - The employee and/or dependent must be eligible under the Plan's terms;
    - When the employee declined enrollment for the employee and/or dependent, the employee stated in writing that the reason for declining enrollment was because they had other coverage, if the Plan requires such a statement and if the employee was notified of the requirement to provide a written statement at the time they declined coverage; and
    - When the employee declined enrollment for the employee and/or dependent, either the employee and/or dependent had COBRA continuation coverage under another plan and that coverage has since been exhausted; or if the other coverage was not under COBRA, either the other coverage has terminated as a result of loss of eligibility, or employer contributions toward the other coverage have terminated.
- **Effective date of enrollment.** Individuals must request enrollment no more than 31 days from the time that the individual knew or should have known that the other coverage has been exhausted. Late enrollment is effective no later than the first day of the calendar month beginning after the date a completed request for enrollment is received by the Plan.
- **Late enrollees due to marriage, birth, adoption, or placement for adoption or foster care.** If a dependent is added through marriage, birth, adoption, or placement for adoption or foster care, the employee and all dependents may apply for coverage through special late enrollment. Individuals in this category do not have to have declined coverage because they had other coverage.
- **Effective date of enrollment.** Individuals must request coverage within 31 days of the marriage, birth, adoption, or placement for adoption. For special enrollment due to birth or adoption, late enrollment is effective on the date of the birth, adoption, or placement for adoption. For special enrollment due to marriage, late enrollment is effective no later than the first day of the calendar month beginning after the date a completed request for enrollment is received by the Plan.
- **Special enrollment for employees and/or dependents that lose eligibility under Medicaid or CHIP coverage.** Employees and/or dependents who are eligible for group coverage will be permitted to enroll late if they either lose eligibility for Medicaid or CHIP coverage or become eligible to participate in a premium-assistance program under Medicaid or CHIP.
- **Effective date of enrollment.** Individuals must request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

Policies/procedures for groups applying for coverage

Employer contribution to premium

Sentara Health Plans requires an employer contribution of at least 50% of the single employee premium. On a dual or triple option basis, Sentara Health Plans requires a contribution of at least 50% of the lowest premium plan. If the employer does not meet this minimum contribution level, rates may be adjusted.

Employer contribution to deductible

Proposed rates for all plans assume that employer contribution to any plan Deductible (through contributions to a Health Savings Account (HSA) or Health Reimbursement Account (HRA), or any other arrangement) will not exceed 50% of the single deductible and/or 50% of the family deductible. Sentara Health Plans reserves the right to adjust rates if Deductible funding for any plan is higher than this 50% assumption.

Principal ownership companies

Principal ownership companies are eligible given the following stipulations:

- There must be a consistent principal owner in all companies (i.e. the same individual holds the largest stake in each company).
- Multiple-partner companies must provide documentation of partnership arrangements—as well as written documentation—signed by all partners outlining parties eligible to authorize changes to the group's employee benefit package and broker arrangements.
- There must be a clear and demonstrable relationship to each of the sub-companies.
- All of the employees will be used to determine rating and plan selection.
- In the event that the group wishes to divide the companies into separate group plans, each company will be separately evaluated to determine rating and plan coverage.

"Class" groups

Sentara Health Plans can administer different coverage for classes of employees. The determination of whether there is discrimination in benefits, premium contribution, and waiting periods will not be made by Sentara Health Plans. Employers must consult with their legal and tax advisors on this matter. Employers that discriminate in their healthcare plans may be subject to financial and tax penalties.

Participation requirements

Groups are recommended to meet 75% participation of eligible employees enrolled in a qualifying health plan. Employees who waive Sentara Health Plans coverage to stay on another qualifying plan (such as Medicare, TRICARE/CHAMPUS, or a spouse's employer-sponsored plan) are considered enrolled employees for the purpose of this calculation.

Participation is a continuing requirement. Failure to maintain the applicable participation level after initial enrollment or anytime during the contract period may result in a rate adjustment.

Work-related illness and/or injury

Work-related illnesses and/or injuries are not covered by SHP or SHIC group policies for groups with more than three employees.

Large Group (151+ eligible employees)

Size and underwriting limits

Large Group is defined as employer groups with 151 or more eligible employees. The number of eligible employees determines if a group is a mid-market group vs. large group, not the number of employees actually enrolling.

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

Companies originally written as large groups that decrease their employee base to fewer than 151 eligible employees during the contract year will remain large groups until renewal. At renewal, such groups will be reviewed on a case-by-case basis to determine their status as a large group vs. mid-market group. The same review will apply to small or mid-market groups that increase above 150 eligible employees during the contract year.

Request for proposals

The broker/consultant should allow a turnaround time of 5–10 business days for large group quotes (151+ eligible), once all data required is provided. For formal RFPs with multiple exhibits, a minimum lead time of four weeks is requested.

The following information is needed to receive a quote from Sentara Health Plans:

- Complete and accurate employee census—showing date of birth, gender, tier, plan, and zip code (indicate Other Coverage or None for those who have not elected coverage)
- group's current and renewal rates
- 24 months of claims experience with corresponding employee and member enrollment by month. Provide report of large claimants for the same 24-month period. Explain any gaps in the experience. If group does not have claims experience, please state why. If no experience, please provide copies of the last two renewals and current (three total)
- Benefit summaries for the experience period, noting any changes during the experience period and whether accumulators were calendar year or plan year
- Employer contribution amounts and/or percentages and waiting period for new hires
- Top facilities and providers used during the experience period
- Requested commission level

Quote and proposal criteria

Large group (151+ eligible) proposed rates will be determined by using a combination of community rating and experience rating, based on the credibility of the claims experience provided. Other characteristics of the group, including—but not limited to—participation, contribution, industry, and carrier persistence are also included in the rate development.

Brokers/consultants should review and follow the most current Large Group Submission Checklist (can be obtained from any member of the Large Group sales team) to ensure a complete submission and to receive a timely response.

Premium check/payments

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

SHP and SHIC will not accept checks from the agency, agent, or broker; or any other third-party payment in lieu of a check from the employer group.

Employee contacts at a glance

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 and benefits.
- View your authorizations.
- View deductible and maximum out-of-pocket accumulators.
- View member guide.
- Download member forms.
- Manage your pharmacy benefit (if administered by Sentara Health Plans).
- Choose to receive your Explanation of Benefits (EOB) electronically.
- Find costs for all covered treatments and services.
- Chat 24/7 with healthbot

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 a.m. to 6 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.

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