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2023 Individual Product BROKER GUIDE

OptimaHealth

INDIVIDUAL & FAMILY PLAN BROKER MANUAL

January 2023

www.optimahealth.com/brokers

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SECTION

1. Introduction

This manual provides information you need to write new Individual & Family Plan business with Optima Health, effective on or after January 1, 2023, and to continue servicing your existing clients. We are dedicated to helping you expand your book of business and retain your current clients.

2. Contact Information

You have online access to optimahealth.com/brokers available 24/7 with helpful resources. We provide up-to-date information and customer sales tools to help you grow your business. It includes many of the functions as our online broker tool, plus some new enhancements.

Sales: Email: IndividualSales@sentara.com
Fax: 1-877-388-3814

Enrollment: Email: Individualuw@sentara.com
Fax: 1-877-388-3814 (Applications)

Member Services: 757-552-7274 or 1-866-514-5916

Broker Services: 1-866-927-4785

For questions about broker checks and payments, please email brokerinquirymailbox@sentara.com.

Website: www.optimahealth.com/brokers

This guide is an overview of our new policies and procedures. Brokers are NOT authorized to make any promises or representations about what type of coverage can be offered or the outcome. The information contained in this manual is intended for use by authorized brokers only and not for distribution to the insurance-buying public.

3. Primary Applicant / Subscriber

The individual applying for the policy is called the primary applicant, or subscriber. This individual must have the legal capacity to contract and be recognized by the Commonwealth of Virginia as the person who becomes the policyholder or policy owner. Child-only policy applications need proper documentation from the parent(s)/legal guardian.

4. Dependents

A dependent is any person who is a member of a primary applicant's family who:

- meets all applicable eligibility requirements of the policy
- is enrolled pursuant to the policy
- is included in the premium amount by the Plan

A dependent may be a spouse and/or child(ren) of the applicant. Children are defined as:

- a natural child
- adopted child
- child placed for adoption
- foster child placed in foster care
- stepchild
- other child, such as grandchild, for whom the plan's subscriber has legal custody

This includes children up to the end of the calendar month in which they turn 26 years of age, regardless of: financial dependency on the subscriber or any other person; residency with the subscriber or any other person; student status; employment status; or marital status.

Children also include the insured's mentally or physically handicapped child over age 26, who, as a result of the disability, is unable to perform self-support. It is not mandatory that the child reside with the applicant.

Dependents can only be added to plans during the open enrollment period or when there is a qualifying event during a Special Enrollment Period. Members adding a dependent to plans off the Marketplace can use the same application used for new business. Members adding a dependent to plans on the Marketplace must notify the Marketplace directly at HealthCare.gov or 1-800-318-2596 / TTY: 1-855-889-4325.

5. Newborn and Adoption Rules

Under a plan that provides coverage for a family member of the subscriber, a newborn child of the subscriber will be covered from the moment of birth for 31 days. An adopted child whose placement occurred within 31 days of birth will be considered a newborn child of the subscriber as of the date of adoptive or parental placement. The newborn child's coverage will be identical to coverage provided to the subscriber.

In order for coverage to continue beyond the first 31 days, the subscriber must add the newborn to the Plan and submit any required premiums within 60 days of the newborn's birth. Adopted children will be eligible for coverage from the date

of placement with the subscriber. An adopted child placed within 31 days of birth will be considered a newborn child of the subscriber as of the date of placement. The subscriber must add the adopted child to the plan and submit evidence of placement and any applicable premiums within 60 days from the date of placement. If an enrollment application and any required premiums are not submitted within 60 days of a qualifying event, (such as the birth, adoption, or placement for adoption), the newborn, adopted child, or other dependent will not be automatically eligible for enrollment under the subscriber's current policy and is subject to all the Plan's application requirements.

The Plan provides maternity and delivery coverage for dependents of the subscriber. A newborn child of a dependent is not eligible for coverage unless the subscriber has legal custody. Coverage for the newborn can be obtained through Optima Health, the Health Insurance Marketplace, or a Medicaid/CHIP program (based on income).

6. Dependent Children Aging Off Plan

Dependent coverage for off-Marketplace plans **ends on the last day of the month the dependent reaches age 26** for covered children. Once the dependent reaches the state-specific attained age of 26 (also called over-age dependent), the dependent will be automatically canceled off the policy on the first of the month. We will send a notification to the subscriber.

Dependents on a Marketplace plan can remain covered through December 31 of the year they turn 26. Dependents aged 26 will not be renewed on their parent's plan January 1.

Dependent handicapped children over age 26 who are both incapable of self-sustaining employment by reason of mental or physical disability and who chiefly are dependent upon the subscriber for support and maintenance will continue to be eligible for coverage beyond the plan's age limits. You must give the plan acceptable proof of incapacity and dependency within 31 days of the child 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 mental or physical disability.

7. Enrollment Periods and Coverage Effective Dates

Open Enrollment Period

Open enrollment for 2023 starts November 2, 2022 and ends January 15, 2023. Member effective dates depend on when they enroll:

- enroll/active and passive renewal: November 1–December 15; effective date is January 1, 2023
- enroll/active renewal: December 16–January 15; effective date is February 1, 2023

Exception: Newborns and adopted children can be added to their parent's existing coverage or enrolled in a separate plan as of the date of birth or placement, as described in Section 5, page 2.

Special Enrollment Periods Outside Open Enrollment Period

Individuals who experience a qualifying event are able to enroll in a plan on or off the Marketplace outside the open enrollment period, known as a Special Enrollment Period (SEP). Documentation/proof of qualifying events is required prior to enrollment. If it is not received, the individual(s) may not be enrolled.

Members requesting a special enrollment to a plan off the Marketplace should use the same application used for new business. Members adding a spouse or dependent to a plan on the Marketplace or other qualifying event must contact the Marketplace directly at HealthCare.gov or 1-800-318-2596 / TTY: 1-855-889-4325.

The Plan provides special enrollment periods of 60 days from the date of a triggering event for enrollees and dependents of enrollees in Individual & Family plans.

Triggering Event

SEP Category	Regulatory Authority under 45 CFR §155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
Loss of qualifying health coverage	(d)(1)(i-iv) Loss of MEC * New Enrollees Subject to SEP-V **(d)(1)(ii) The end of the plan year for any non-calendar year group health coverage is not applicable in SHOP Exchanges ****Existing enrollees will generally be limited to plan options within their current plan category.	A QI or their dependent loses MEC, including but not limited to Medicaid, CHIP, or qualifying employer sponsored coverage. For purposes of qualifying for this SEP, this includes: The end of the plan year for any non-calendar year group health plan or individual health insurance coverage, including a non-calendar year individual coverage HRA or a QSEHRA; Losing pregnancy-related coverage described under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act or access to healthcare services through coverage provided to a pregnant Losing medically needy coverage described under section 1902(a)(10)(C) of the Social Security Act only once per calendar year. NOTE: This does not include QIs who have lost their coverage due to nonpayment of premiums, voluntary termination, or as a result of an act of fraud by the QI (or other act that would qualify for rescission) (per 155.420(e)). Coverage Effective Dates: Plan selection after Loss of MEC: 1st of the month after plan selection. Plan selection prior to or on the date of the Loss of MEC: 1st of the month following the loss of MEC	07	Application

Loss of qualifying health coverage (continued)	(d)(6)(iii) Become newly eligible for advance payments of the premium tax credit (APTC) due to changes to current employer sponsored coverage *New enrollees subject to SEP-V **Not applicable in SHOP Exchanges ****Existing enrollees will generally be limited to plan options within their current plan category.	A QI or their dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for APTC based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR §1.36B-2(c)(3). **Coverage Effective Dates:** Plan selection after loss of MEC: 1st of the month after plan selection. Plan selection prior to or on the date of the loss of MEC: 1st of the month following the loss of MEC.	07	Application
Change in household size	(d)(2)(i) Gain a dependent or become a dependent *New enrollees subject to SEP-V if gaining/becoming a dependent through marriage, adoption, placement for adoption, placement in foster care, or a child support or other court order. (New enrollees gaining a dependent through birth are not currently subject to SEP-V.) **The SEP at (d)(2)(ii) Loss of dependent due to divorce, legal separation or death is offered at the option of the Exchange and is not currently available in the FFEs. ***Existing enrollees will generally be limited to their current plan.	A QI gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order. **Coverage Effective Dates:** Marriage: 1st of the month after plan selection. Birth, adoption, foster care placement, court order: Retroactive back to the date of the event. **NOTE:** For birth, adoption, placement for adoption, or placement in foster care, or court order, individuals may alternatively request a coverage effective date of the first day of the month following the date of plan selection or following regular prospective coverage effective dates by calling the Marketplace Call Center. **NOTE:** For marriage, at least one spouse must have MEC as described for one or more days during the 60 days preceding the date of marriage, or meets one of the following criteria: lived for one or more days during the 60 days preceding the qualifying event in a foreign country or a United States territory; or lived for one or more days during the 60 days preceding the qualifying event or during their most recent preceding enrollment period, in a service area where no QHP's were available on the Exchange; or is an Indian as defined by Section 4 of the Indian Health Care Improvement Act. This requirement does not apply in the FF-SHOP. Verification of this requirement has not yet been implemented in the FFEs.	Birth: 02 Marriage: 32 Adoption/ Foster Care Placement/ Court Order: 05	Application

Change in primary place of living	(d)(7) Gain access to new QHPs due to a permanent move *New enrollees subject to SEP-V **Existing enrollees will generally be limited to plan options within their current plan category.	A QI or enrollee, or their dependent, gains access to new QHPs as a result of a permanent move. The QI, enrollee, or dependent must also have had MEC for one or more days in the 60 days prior to the move, unless he or she meets one of the following criteria: lived for one or more days during the 60 days preceding the qualifying event in a foreign country or a United States territory; or lived for one or more days during the 60 days preceding the qualifying event or during their available on the Exchange; or is an Indian as defined by Section 4 of the Indian Health Care Improvement Act. **NOTE:** Moving solely for medical treatment or vacation would not be considered a permanent move for purposes of qualifying for this SEP. **Coverage Effective Dates:** Regular prospective coverage effective dates. **NOTE:** At the option of the Exchange, this SEP can be available 60 days prior to the move. However, the FFEs do not offer advanced availability for this SEP at this time	43	Application
Change in eligibility for Exchange coverage or help paying for coverage	(d)(3) Become newly eligible for QHP coverage *Not applicable in SHOP Exchanges **Existing enrollees will generally be limited to plan options within their current plan category	A QI or their dependent becomes newly eligible for enrollment in a QHP due to gaining status as a citizen, national, or lawfully present individual or being released from incarceration. **NOTE:** QIs who change from one legally present status to another do not qualify for this SEP. **Coverage Effective Dates:** Regular prospective coverage effective dates. **NOTE:** At the option of the Exchange, this SEP can be available 60 days prior to the change in eligibility for QHP coverage. However, the FFEs do not offer advanced availability for this SEP at this time.	NE	Application

Change in eligibility for Exchange coverage or help paying for coverage (continued)	(d)(6)(i-ii) Become newly eligible or ineligible for APTC, or experience a change in eligibility for CSR *Not applicable in SHOP Exchanges **Current enrollees who are newly eligible for CSR are generally limited to either current plan category or Silver plans	An enrollee or their dependent is determined newly eligible or newly ineligible for APTC or has a change in eligibility for CSR. NOTE: This SEP is only available to current Exchange enrollees. Coverage Effective Dates: Regular prospective coverage effective dates.	FC	Application
Change in eligibility for Exchange coverage or help paying for coverage (continued)	(d)(6)(iv) Previously in the coverage gap and become newly eligible for APTC *Not applicable in SHOP Exchanges **Existing enrollees will generally be limited to plan options within their current plan category	A QI who was previously ineligible for APTC solely because of a household income below 100 percent of the FPL and who, during the same timeframe, was ineligible for Medicaid because he or she was living in a non-Medicaid expansion state, who either experiences a change in household income or moves to a different state resulting in the QI becoming newly eligible for APTC. **Coverage Effective Dates:** Regular prospective coverage effective dates. **NOTE**: At the option of the Exchange, this SEP can be available 60 days prior to the move. However, the FFEs do not offer advanced availability for this SEP at this time.	EX	CMS Caseworker via Marketplace Call Center
Change in eligibility for Exchange coverage or help paying for coverage (continued)	(d)(6)(v) Off-Exchange enrollee experiences a decrease in household income and new determination of eligibility for APTC *New enrollees are subject to SEP-V (to verify decrease in income and prior coverage) **Not applicable in SHOP Exchanges	At the option of the Exchange, a QI and their dependent who experiences a decrease in household income and is 1) newly determined eligible for APTC by an Exchange, and 2) had MEC as described in 26 CFR §1.5000A-1(b) for one or more days during the 60 days preceding the Change in Circumstance (CIC). **Coverage Effective Dates:** Regular prospective coverage effective dates	EX	CMS Caseworker via Marketplace Call Center

Change in eligibility for Exchange coverage or help paying for coverage (continued)	(d)(8)(i-ii) Gain or maintain status as a member of a federally recognized tribe or a shareholder in an Alaska Native Corporation	A QI who is an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, gains or maintains such status and may enroll in a QHP or change from one QHP to another one time per month. A QI who is or becomes a dependent of an Indian and is enrolled or is enrolling in a QHP through an Exchange on the same application as the Indian, may change from one QHP to another one time per month, at the same time as the Indian. **Coverage Effective Dates:** Regular prospective coverage effective dates.	NE	Application
Enrollment or plan error	(d)(4) Experience an error of the Exchange	A QI's or their dependent's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities. **Coverage Effective Dates:** Appropriate date based on the circumstances of the SEP. Typically, retroactive back to the coverage effective date the QI would have gotten absent the error or regular prospective coverage effective date, at the option of the QI. **NOTE:** There are some exceptions for certain types of errors.	EX	Marketplace Call Center
Enrollment or plan error (continued)	(d)(5) Experience a plan contract violation	An enrollee or their dependent adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee. **Coverage Effective Dates:** Appropriate date based on the circumstances of the SEP. Typically retroactive back to the coverage effective date the QI would have gotten absent the error or regular prospective coverage effective date, at the option of the QI.	EX	CMS Caseworker

Enrollment or plan error (continued)	(d)(12) Material error related to plan benefits, service area, or premium	The QI, enrollee, or their dependent, adequately demonstrates to the Exchange that a material error related to plan benefits, service area, or premium influenced the QI or enrollee's decision to purchase a QHP through the Exchange. **Coverage Effective Dates:** Appropriate date based on the circumstances of the SEP. Typically, retroactive back to the coverage effective date the QI would have gotten absent the material error or regular prospective coverage effective date, at the option of the QI	EX	CMS Caseworker
Other qualifying charges	(d)(9) Experience an exceptional circumstance	A QI's, enrollee's, or their -enrollment in a QHP is the result of an exceptional circumstance, as determined by the Secretary of HHS, including being incapacitated or experiencing a natural disaster. The enrollment or non-enrollment of a QI, enrollee, or their dependent in a QHP is the result of an unforeseen event or reflects a first-time requirement for Exchange enrollees (such as the Tax Season SEP for individuals impacted by the individual shared responsibility payment). The enrollment or non-enrollment of a QI, enrollee, or their dependent, enrollment or non-enrollment in a QHP is the result of a significant life event resulting in lack of access to their application or account and the individual, enrollee, or dependent has experienced a change in situation or status that now requires that he or she obtain MEC. This includes victims of domestic abuse or spousal abandonment. This also includes AmeriCorps servicemen and women who are starting or ending their service. **Coverage Effective Dates:** Vary based on circumstances.	EX	CMS Caseworker, Marketplace Call Center (in some cases, Application)

Other qualifying charges (continued)	(d)(10) Domestic abuse/Spousal abandonment	A QI is a victim of domestic abuse or spousal abandonment, as defined by 26 CFR 1.36B-2, including a dependent or unmarried victim within a household, is enrolled in MEC and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment. A dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim. **Coverage Effective Dates:** Regular prospective coverage effective dates.	EX	Marketplace Call Center
Other qualifying charges (continued)	(d)(13) Resolution of data matching issue (DMI) or verification of citizenship/lawful presence status *This SEP is offered in the FFEs but is optional for Exchanges. ** Not applicable in SHOP.	The QI provides satisfactory documentary evidence to verify their eligibility for an insurance affordability program or enrollment in a QHP through the Exchange following termination of Exchange enrollment due to a failure to verify such status within the time period specified in §155.315 or is under 100% of the FPL and did not enroll in coverage while waiting for HHS to verify their citizenship status as a national or lawful presence. **Coverage Effective Dates:** Appropriate date based on the circumstances of the SEP. Typically, retroactive coverage is back to date of termination.	NE	Marketplace Call Center

Other qualifying charges (continued)	(d)(14) Newly gains access to an individual coverage HRA, or newly provided with a QSEHRA	The QI, enrollee, or dependent newly gains access to an individual coverage HRA (as defined in 45 CFR 146.123(b)), or is newly provided a QSEHRA, as defined in section 9831(d)(2) of the Internal Revenue Code. A QI, enrollee, or dependent will qualify for this SEP regardless of whether they were previously offered or enrolled in an individual coverage HRA or previously provided a QSEHRA, so long as they are not enrolled in the individual coverage HRA or provided the QSEHRA on the day immediately prior to the triggering event, which is the first day on which coverage under the individual coverage HRA can take effect, or the first day on which coverage under the QSEHRA takes effect. **Coverage Effective Dates:** Individuals who qualify for this SEP have 60 days before their HRA start date to select a QHP, unless the HRA was not required to provide the notice setting forth its terms to them at least 90 days before the beginning of the plan year, in which case they have 60 days before or after their HRA start date to select a QHP. • Plan selection prior to triggering event: 1st of the month following the triggering event; if the triggering event is on the first day of a month, on the date of the triggering event. • Plan selection on or after triggering event: 1st of the month after plan selection.	Individual coverage HRA: HR QSHERA: QS	Application

Documentation Needed

A qualified individual or dependent loses minimum essential coverage.

- Requires a letter from the benefit administrator of the employer-sponsored coverage, indicating start and end dates of coverage and reason for termination

- A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, or placement for adoption.
  - Marriage requires a copy of the marriage certificate.
  - Birth requires a copy of the birth certificate (only if date of birth is more than 31 days), or hospital letter if under 31 days.
  - Adoption or placement for adoption or foster care requires a copy of the adoption/placement document (only if adoption/placement is more than 31 days).

- A qualified individual becomes a US citizen, a national or lawfully present individual; includes documentation of proof of lawfully present individual i.e. lawful permanent resident (LPR/green card holder), asylum, refugee, Cuban/Haitian entrant, paroled into the U.S., conditional /entrant granted before 1980, battered spouse child and parent, victim of trafficking and his/her spouse, child sibling or parent, granted withholding of deportation or withholding of removal, under the immigration laws or under the convention against torture (CAT), individual with non-immigrant status (includes worker, visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau), temporary protected status (TPS), deferred enforced departure (DED). lawful temporary resident, administrative order staying removal issued by the department of homeland security, member of a federally recognized Indian tribe or American Indian born in Canada, resident of American Samoa, temporary protected status with employment authorization, special immigrant juvenile status, victim of trafficking visa, adjustment to LPR status, asylum (only those who have been granted employment authorization or are under the age of 14 and have had an application pending for at least 180 days eligible), withholding of deportation or withholding or removal, under the immigration laws or under the Convention Against Torture (CAT).
  - The following documents may be required or used depending on the individual situation:
  - Permanent Resident Card, “Green Card” I-551
  - Reentry Permit I-327
  - Refugee Travel Document I-571
  - Employment Authorization Card I766
  - Machine Readable Immigrant Visa (with temporary I-551 language)
  - Temporary I-551 Stamp (on passport or I-94/I-94A)
  - Arrival/Departure Record (I-94/I-94A)
  - Arrival/Departure Record in foreign passport (I-94)
  - Foreign Passport
  - Certificate of Eligibility for Nonimmigrant Student Status (I-20)

    - Certificate of Eligibility for Exchange Visitor Status (DS2019)
    - Notice of Action (I-797)
    - Certification from US Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
    - Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
    - Document indicating withholding of removal
    - Administrative order staying removal issued by the Department of Homeland Security
    - Alien or I-94 number
    - Documentation indicating membership in a federally recognized Indian tribe or American Indian born in Canada
- A qualified individual's enrollment or non-enrollment in a Qualified Health Plan (QHP) is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Marketplace or HHS, or its instrumentalities as evaluated and determined by the Marketplace.
    - Requires documentation for proof of the error

- An enrollee adequately demonstrates to the Marketplace that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.
    - Requires documentation for proof of the violation

- A qualified individual or enrollee gains access to new QHPs as a result of a permanent move.
    - Requires rental/lease agreement/utility hook up order or utility statement issued by the service provider, interim/temporary driver license/ID/permit; Any item delivered by the USPS, FedEx, or UPS sent by a verifiable business or government agency; personal mail; any document issued by a financial institution that includes residence address such as bank statement, loan statement, dividend statement, credit card bill, etc.

- An Indian, as defined by the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month.
    - Requires documentation for proof of membership in a federally recognized Indian tribe or American Indian born in Canada

- A qualified individual or enrollee demonstrates to the Marketplace, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Marketplace may provide.
    - Requires documentation for proof of the exceptions

On-Marketplace applicants are not enrolled in a plan and/or any changes to their current enrollment are not effective until all required documentation is received by the Marketplace.

If an applicant applies outside of the annual open enrollment period due to a qualifying event, and his or her application is approved and full initial month's premium is received, the effective date will be as follows:

- In the case of birth, adoption, or placement for adoption, coverage is effective on the date of the birth, adoption, or placement for adoption.
- In the case of all other qualifying events, coverage is effective on the first day of the following month after the application is received.

8. Eligibility

To be eligible to enroll for coverage in an Individual & Family plan, all applicants must:

- Be a U.S. citizen or national, or be a lawfully present non-citizen for the entire period for which coverage is sought;
- Be a legal resident of the state in which they are applying;
- Be under age 65;
- Submit satisfactory proof to Optima Health to confirm dependent eligibility, if requested;
- Agree to pay for the cost of premium Optima Health requires;
- Reveal any coordination of benefits arrangements or other health benefit arrangement for the applicant or dependents as they become effective;
- Not be incarcerated (except pending disposition of charges);
- Not enrolled in Medicare Parts A/B and or D; and
- Reside or work in the Optima Health designated service area.

9. Military Service

An applicant or dependent on active duty with any branch of the Armed Services is eligible to apply for an Individual & Family plan.

10. Application and Payment Submission

Applications

Online: Applications and initial premium payment can be submitted online 24 hours a day, 7 days a week on our website.

If the initial payment is returned, the policy will be terminated back to the effective date of coverage.

Tips for Completing an Application

Failure to complete a health insurance application may cause delays in processing. Please verify the following items are completed before submitting your client's application:

- All demographic questions;
- Social Security number;
- Effective date desired;
- Coverage plan; and
- All payment information, including the bank address. The applicant (and spouse, if applying) and agent must sign and date the application. Dependents 18 years of age or older also need to sign and date the application. For child-only applications, the parent/legal guardian must sign and date the application.

If information is missing from the application, Optima Health will send a letter to the broker and/or applicant indicating what is needed. If the missing information is not provided within 10 calendar days, the application will be returned. Effective dates will be determined by when the application is completed, not by when it is submitted.

Application Tracking and Status Updates

After an online application is submitted, you can view status of the application in the broker portal.

Payments

Initial premium payment is required and must be paid prior to the plan's effective date. The initial payment will only be processed when a policy is issued. Initial payment must be cash, personal check, money order, cashier's check, ACH payment, or pre-paid debit or credit card.

On-going payments can be accepted via ACH, pre-paid debit card, credit card, personal check, money order, cash or cashier's check. Cash payments can be accepted at MoneyGram® locations throughout Virginia, including 7-Eleven, CVS, and Walmart. There is no fee to use this service; members only need to know their member ID number, receive code 15084, and monthly premium amount.

11. Cancellation of Coverage

A member may cancel their plan/policy at any time. Individual & Family plan policies are not automatically cancelled when transferring to an Optima Health Group plan, a Medicaid plan, or a Medicare plan. In these cases, the member must request cancellation of the Individual coverage in writing.

For Marketplace plans, cancellation requests must be handled directly with the Marketplace.

Cancellation for Non-Payment of Premium

Individuals must pay all premiums when due. A 31-day grace period will be provided for all premiums due except for the initial premium payment. When premiums are not paid, plans/policies will terminate at the end of the grace period. Full premium will be required prior to the end of the grace period in order for coverage to continue.

Members who purchase coverage through the Marketplace and receive an Advanced Premium Tax Credit have a 90-day grace period before their plan is cancelled for non-payment. Any claims incurred after the first 31 days of the 90-day period will be pended until all outstanding premiums are paid in full. If all past due premiums are not paid in full by the last day of the 90-day grace period, coverage will end effective the last day of the initial 31-day grace period.

When coverage is cancelled for non-payment and the subscriber seeks enrollment in another individual plan from the same issuer—either during special enrollment or during the next open enrollment period—we may require that the subscriber pay all past due premium amounts owed to us for coverage in the prior 12 months, and any applicable binder payments for the new coverage. This does not apply to any dependents covered under the prior plan that seek future enrollment in their own plan.

Termination of the Qualified Health Plan or Qualified Health Plan Issuer

The Plan may terminate coverage under the member's policy as permitted under the terms of our agreement with CMS and the Exchange and applicable state law. The member will be notified by us as required by applicable state and federal law.

12. Address and Contact Information Updates

Members may change their address of record by contacting Member Services by phone or in writing, or by contacting their broker.

Brokers submitting the address change on their client's behalf must submit the change in writing, by fax, or email to Broker Services. Please see Section 2 for phone numbers, email addresses, and other contact information.

Members enrolled in plans on the Marketplace need to contact the Marketplace directly for address changes at HealthCare.gov or 1-800-318-2596 / TTY: 1-855-889-4325.

Note: For both on- and off-Marketplace plans, if your client moves from one geographical rating area to another, their rates may be subject to change.

13. Broker Individual Website: Optimahealth.com/brokers

From the broker portal, (eBroker), you can easily manage new and existing clients at any time of the day. To access the secure features of the broker portal, including client information, you must complete a two-step login process.

eBroker: Our online portal gives you flexibility in working with us and serving clients in the Individual Product, Mid-Market and Small Group segments. You can request quotes, manage your groups, complete renewals and view report activity.

Broker Book of Business Dashboard: Access to number of current clients, membership by group segment, year to date total premiums paid, upcoming renewals, and historical client/membership growth for all lines of business.

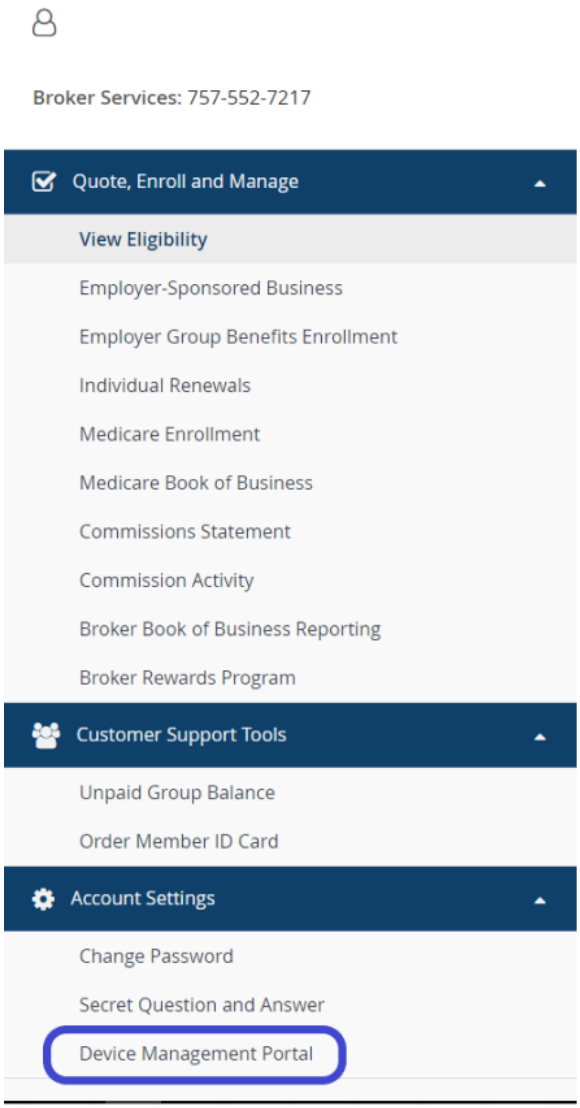
Commissions Dashboard: You can view your commissions by weekly payment detail, quarterly trends, year to date total, and year to date by client.

Resources: Access to sales materials and educational content so you can stay informed about the latest news with Optima Health and health insurance industry trends.

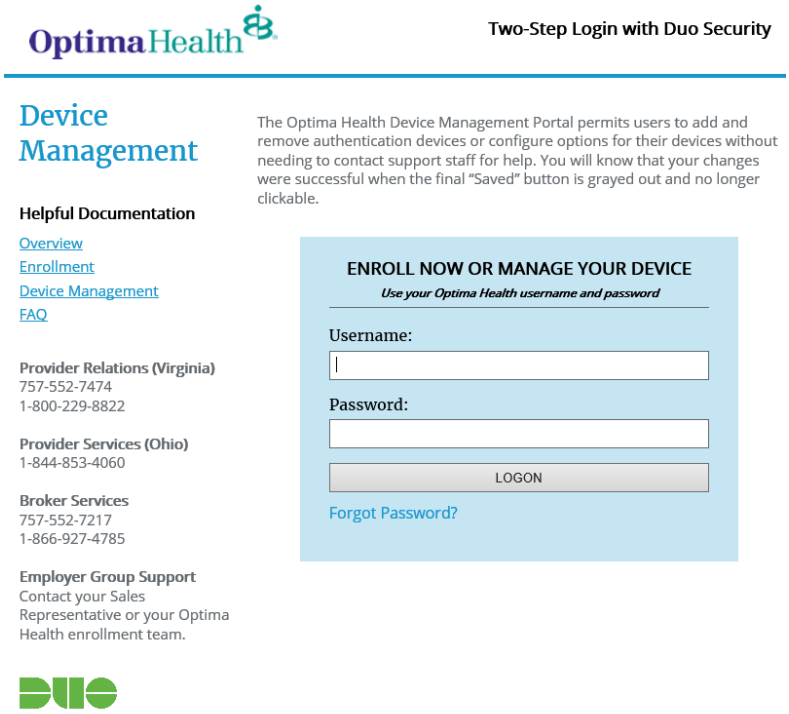
Optima Health Broker Rewards Program: Sell a plan, earn a reward. Smile. Repeat. *Simple*. Find out how you can become an eligible broker and start earning points! Make a wish list and set a goal towards your favorite rewards! You can exchange your points for: name-brand merchandise, travel, tickets for local events, gift cards, charitable donations and much more! Learn more. Sign in required.

To set up your computer, phone, and other devices:

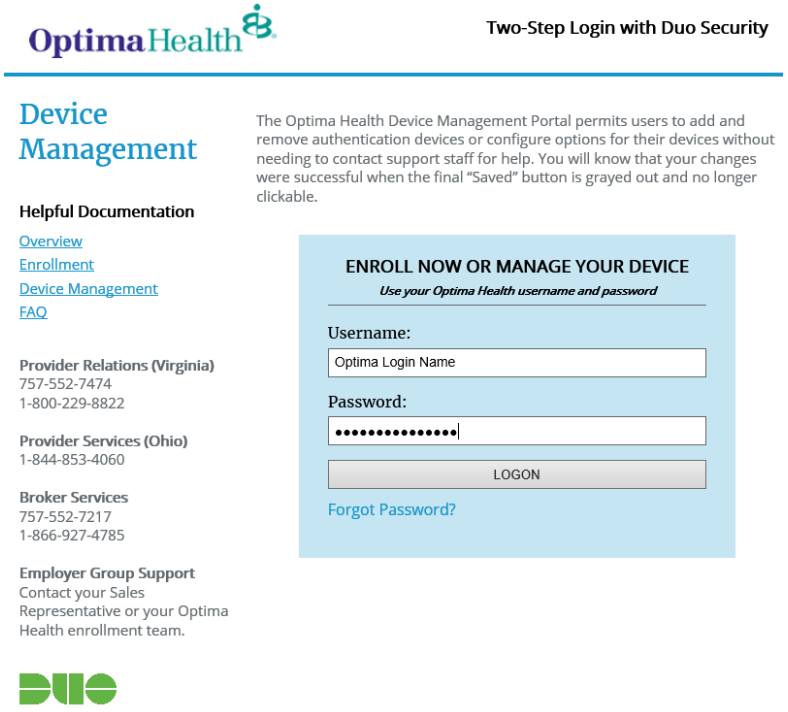
- Sign into optimahealth.com Broker portal, select “Device Management Portal”:



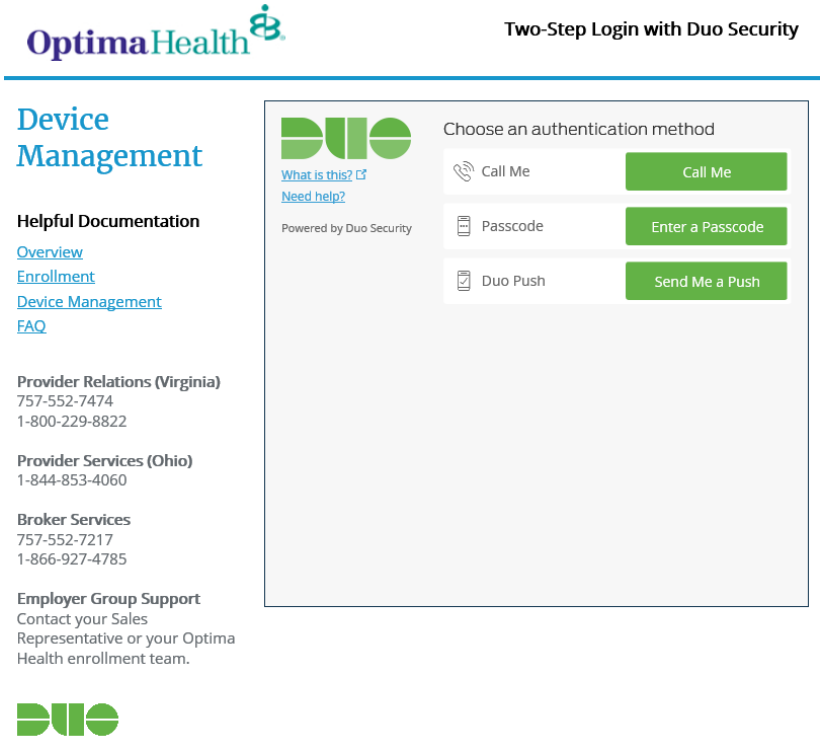
- You should see this screen:



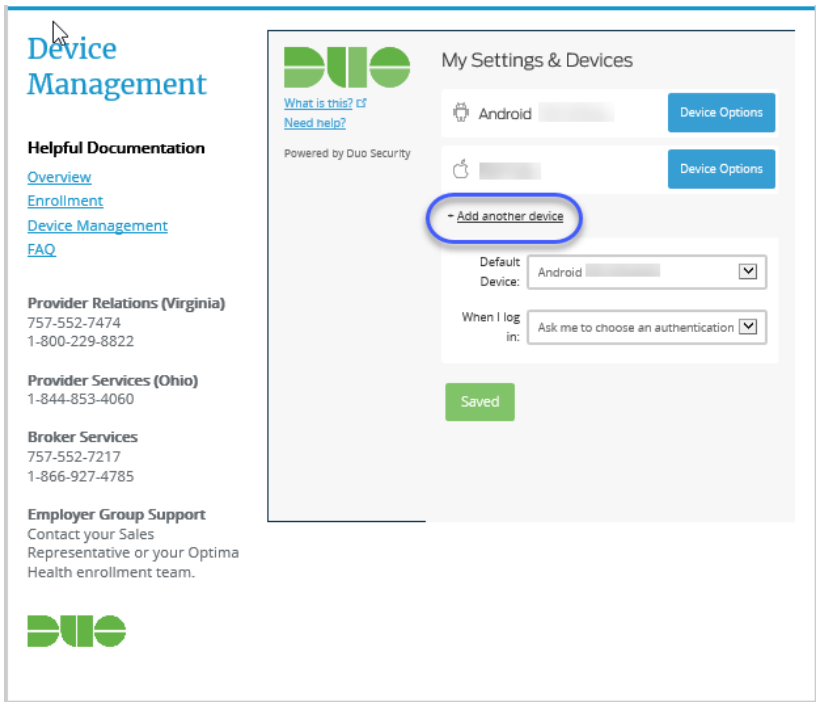
- Sign in using your optimahealth.com username and password:



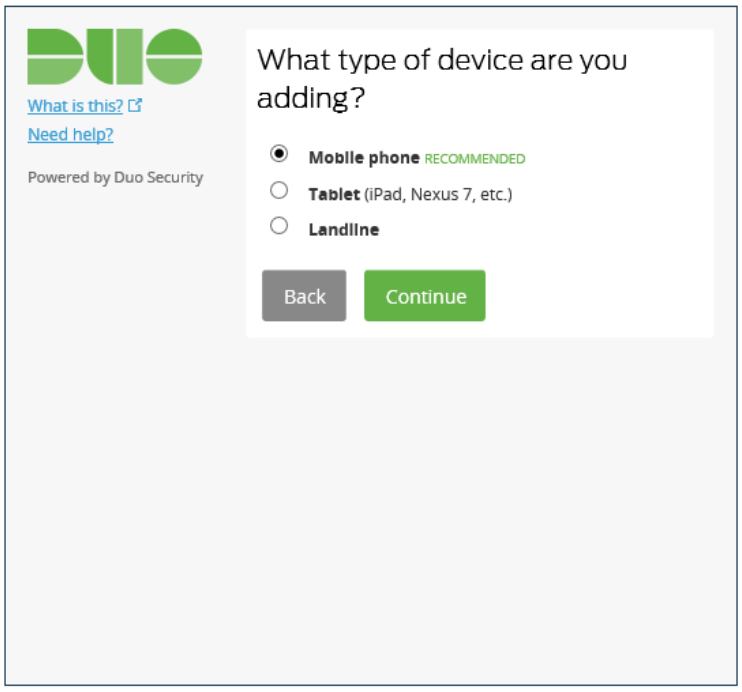
- Select your authentication method:



- Once authenticated you will see this screen:



- If you select “Add Another Device,” you can add a second mobile phone or a landline. Adding other devices allows you select a default device.



After you have signed up the devices you wish to use, then when you sign in to optimahealth.com, you will be prompted to authenticate your device. You will only need to authenticate your device once every 24 hours.

- **Applications**: Brokers can complete entire application on the client’s behalf—by doing so broker is attesting their electronic signature is on the client’s behalf.
- **Case Updates**: For assistance or training, please call Broker Services at 1-866-927-4785.
- **Approved Applications**: Approved applications will be automatically enrolled.

Online Services for Members

All subscribers and their dependents over age 18 can register online at optimahealth.com and the Optima Health mobile app (text APP to 59270) and access their account, policy, and claims information at any time. Members who purchased their plan off the Marketplace can also update personal and contact information. Members who purchased their plan on the Marketplace must log in to their account on HealthCare.gov to update contact information or make policy or plan changes. Brokers, please encourage your clients to register at optimahealth.com or the Optima Health mobile app.

14. Agent/Broker Appointment and Commissions

Agents/brokers must be appointed to Optima Health before they can represent our products and receive compensation. Please visit optimahealth.com/brokers to view our broker compensation program. Online registration is required.

As a QHP issuer participating on the Health Insurance Marketplace, Optima Health is required to ensure that its affiliated agents and brokers comply with applicable laws and regulations, to include monitoring applicable Marketplace registration and training requirements. As a result, the Plan will verify that all agents electing to sell on the Marketplace have completed the required agreements and certifications.

Commissions are typically paid 7–14 business days after the receipt of premiums. For commission questions please email brokerinquirymailbox@sentara.com.

15. Administrative Letters That Should Be Reviewed by Every Agent

There are a number of administrative letters that should be carefully reviewed by any person licensed as an insurance agent in Virginia. Specifically, licensees should review, at a minimum, the following (found online at https://www.scc.virginia.gov/pages/Administrative-Letters-to-be-Reviewed

Letter - Subject	Life & Annuities	Health	Property & Casualty	Title
Address Changes				
2006-07 - Online Address Changes	X	X	X	X
Adverse Underwriting Decisions				
2015-07 - Requirements for Adverse Underwriting Decisions and Notices; Withdrawal of Administrative Letters 1978-4; 1978-9; 1978-11; 1981-4; 1981-15, 1981-16, and 2003-06	X	X	X	X
1981-15 - Adverse Underwriting Decisions	X	X		
1981-16 - Adverse Underwriting Decisions			X	
Agent Appointments				
2002-01 - Procedures To Recognize Military Call-Up To Active Duty - Agent Licensing and Agent Appointment Processes	X	X	X	X
Agent Licensing				
2010-02 - Online Printing of Producer Licenses	X	X	X	X
2007-05 - Administrative Changes and Changes in Laws Governing Agent Licensing	X	X	X	X
2007-04 - Change in Vendor Providing Insurance License Examinations	X	X	X	X
2006-11 - Procedural change: Displaying National Producer Numbers (NPN) in Lieu of Social Security/DMV-Assigned Numbers	X	X	X	X

2006-04 - Implementation of Procedure Change in Requesting a Duplicate License	X	X	X	X
2006-01 - Implementation of Procedure Change in Requesting Letters of Certification	X	X	X	X
2005-09 - Implementation of electronic non-resident licensing (eNRL) with electronic funds transfer for licensing fees	X	X	X	X
2004-03 - Procedural changes, administrative changes and clarifications regarding agent licensing and the Bureau's Agent Licensing Section	X	X	X	X
2002-09 - Insurance Activities Requiring Persons To Be Licensed	X	X	X	X
2002-08 - Changes in Laws Governing Licensing of Various Types of Insurance Agents And Procedures	X	X	X	X
2002-08 - License Conversion Table of Virginia License Types	X	X	X	X
2002-01 - Procedures To Recognize Military Call-Up To Active Duty - Agent Licensing and Agent Appointment Processes	X	X	X	X
Certificates of Insurance				
2012-07 - Certificates of Insurance – Unfair Trade Practices			X	
2011-02 - Certificates of Insurance – Misuse			X	
Continuing Education				
2013-02 - Revisions to the Virginia Insurance Continuing Education Program Requirements, effective January 1, 2013	X	X	X	X
Flood Insurance				

2007-01 - Flood Insurance Training Requirements for Insurance Agents with a Property and Casualty License or Personal Lines License Selling through the National Flood Insurance Program (NFIP)			X	
Health Insurance Sales				
2001-09 - SCC Advises Agents to Beware when Selling Health Insurance Coverage	X	X		
Long-Term Care Insurance Sales				
2007-03 - Chapter 200 of Title 14 of the Virginia Administrative Code Rules Governing Long-Term Care Insurance Long-Term Care Partnership Program	X	X		
Military				
2008-03 - Rules Governing Military Sales Practices (14 VAC 5-420-10 et. seq.)	X	X		
2002-01 - Procedures To Recognize Military Call-Up To Active Duty - Agent Licensing and Agent Appointment Processes	X	X	X	X
Privacy and GLBA				
2012-04 - Revised Gramm-Leach-Bliley Act Privacy Notices; Withdrawal of Administrative Letter 2011-06	X		X	
2003-04 - Senate Bill No. 878 Privacy Safeguards	X	X	X	X
Sircon				
2010-02 - Online Printing of Producer Licenses	X	X	X	X
2008-11 - Implementation of the New Bureau of Insurance Sircon for States System	X	X	X	X
2006-01 - Implementation of Procedure Change in Requesting Letters of Certification	X	X	X	X
Title Insurance				

2005-03 - Title Insurance - Negotiating Title Insurance Risk Rates				X
2003-03 - Title Insurance - Unfair Discrimination				X
1995-08 - Title Insurance - Closing Protection Letters				X
1992-06 - Title Insurance - Kickbacks, Rebates, Commissions, and Other Payments				X
1978-08 - Title Insurance - Filing Requirements				X
Vendor – License Examinations				
2007-04 - Change in Vendor Providing Insurance License Examinations	X	X	X	X
Summary of Legislation Enacted 2010-2017				
2017-02 - Insurance-Related Legislation Enacted by the 2017 Virginia General Assembly	X	X	X	X
2016-04 - Insurance-Related Legislation Enacted by the 2016 Virginia General Assembly	X	X	X	X
2015-10 - Insurance-Related Legislation Enacted by the 2015 Virginia General Assembly	X	X	X	X
2014-04 - Legislation Enacted by the 2014 Virginia General Assembly	X	X	X	X
2013-05 - Legislation Enacted by the 2013 Virginia General Assembly	X	X	X	X
2012-05 - Legislation Enacted by the 2012 Virginia General Assembly	X	X	X	X
2011-04 - Legislation Enacted by the 2011 Virginia General Assembly	X	X	X	X
2010-06 - Legislation Enacted by the 2010 Virginia General Assembly	X	X	X	X
Summary of Legislation Enacted 2000-2009				

2009-05 - Legislation Enacted by the 2009 Virginia General Assembly	X	X	X	X
2008-08 - Legislation Enacted by the 2008 Virginia General Assembly	X	X	X	X
2007-06 - Legislation Enacted by the 2007 Virginia General Assembly	X	X	X	X
2006-10 - Legislation Enacted by the 2006 Virginia General Assembly	X	X	X	X
2005-10 - Legislation Enacted by the 2005 Virginia General Assembly	X	X	X	X
2004-05 - Legislation Enacted by the 2004 Virginia General Assembly	X	X	X	X
2003-05 - Legislation Enacted by the 2003 Virginia General Assembly	X	X	X	X
2002-05 - Legislation Enacted by the 2002 Virginia General Assembly	X	X	X	X
2001-03 - Legislation Enacted by the 2001 Virginia General Assembly	X	X	X	X
2000-08 - Legislation Enacted by the 2000 Virginia General Assembly	X	X	X	X

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Virginia Beach, VA 23462

Sales
Email: IndividualSales@sentara.com
Fax: 1-877-388-3814

Enrollment
Email: Individualuw@sentara.com
Fax: 1-877-388-3814 (Applications)

www.optimahealth.com