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Important Changes to Your Health Benefits Plan Coverage

Dear Member:

Enclosed is the Amendment/Notification of Changes and Clarifications to your ***COVA Care Member Handbook*** that became effective January 1, 2021. The COVA Care Member Handbook, and this Amendment, may be found at **www.dhrm.virginia.gov**.

Thank you.

A10535 (Eff. 1/1/2021)

COVA Care

Commonwealth of Virginia Health Benefits Program
Amendment/Notification of Changes and Clarifications to Your July 2020 COVA Care Member Handbook

Effective January 1, 2021

Keep this notification with your COVA Care Member Handbook and previous Amendments. This notification and your member handbook constitute a full and complete description of your coverage. You also may view or download the COVA Care Member Handbook and this Amendment from the DHRM Web site at **www.dhrm.virginia.gov**.

Revised language is in bold.

Add the following benefit provisions

I. DEFINITIONS – (Page 14)

Hospitalist
This is a clinician whose primary professional focus is the general medical care of hospitalized patients. Hospitalists engage in clinical care, teaching, research and enhancing the performance of hospitals and healthcare system.

Out-of-Network
When Providers, hospitals and other health care Providers/services have not contracted with the Plan Administrator to deliver health care services to its members they are considered Out-of-Network. For Medical and Behavioral Health services, except in an Emergency, members do not have Out-of-Network benefits unless they have purchased the Out-of-Network option.

The exception to this is the Balance Billing Protection for Out-of-Network Services in the Commonwealth of Virginia (see General Rules Governing Benefits Section).

II. GENERAL RULES GOVERNING BENEFITS – (Page 23)

6) Balance Billing Protection for Out-of-Network Services in the Commonwealth of Virginia

When you receive emergency services from an Out-of-Network health care provider or receive Out-of-Network surgical or ancillary services, (like surgery, anesthesiology, pathology, radiology, laboratory, or hospitalist services) provided at an In-Network facility, the Out-of-Network Providers within the Commonwealth of Virginia cannot charge you the difference between their bill and Your Health Plan's Allowable Charge. Under these circumstances, your cost share shall be determined using the Plan's median in-network contracted rate for the same or similar service in the same or similar geographical area. The Plan will provide you with an Explanation of Benefits that reflects the cost share requirement.

7) Payment to Out-of-Network Medical or Behavioral Health Providers

Except in an Emergency, you do not have Out-of-Network benefits unless you purchased the Out-of-Network option. When a member receives services from a non-network Medical or Behavioral Health services Provider and has purchased the Out-of-Network benefit, the Plan Administrator may choose to make payment directly to you or, at the Plan Administrator's sole option, to any other person responsible for payment of the Provider's charge. Payment will be made only after the Plan Administrator has received an itemized bill and the Medical information the Plan Administrator decides is necessary to process the claim. If the payment is made directly to you, you will be responsible for sending payment to the Provider. You also will be responsible for the difference between Your Health Plan's allowance and the Provider's charge. Payment by the Plan Administrator will relieve it and Your Health Plan of any further liability for the non-network Provider's services.

There is an exception. Under the Balance Billing for Out-of-Network services in the Commonwealth of Virginia, Your Health Plan will pay the Out-of-Network medical provider directly when you receive (1) emergency care or (2) when you receive lab or professional services (like surgery, anesthesiology, pathology, radiology, laboratory, or hospitalist services) at an In-Network Facility.

III. OUT-OF-NETWORK – (Page 85)

These services are covered only if you have selected the Out-of-Network option and pay an additional premium.

Under the COVA Care Basic plan, except in an Emergency, you do not have coverage for the services of Providers and Facilities outside of the Anthem Medical, Behavioral Health and BlueCard PPO networks. This option gives you coverage if you choose to go outside of those networks for Medical and Behavioral Health services.

The Out-of-Network benefit will always be the in-network benefit less a 25% reduction in the amount paid by Your Health Plan. You will be responsible for any Deductible, Coinsurance or Copayment that applies. You also pay any amount the non-network Provider or Facility charges over the Allowable Charge (Balance Bill). Payments for Out-of-Network claims are paid directly to you rather than to the Provider. It is your responsibility to pay the Out-of-Network Provider or Facility.

The Out-of-Network option allows the accumulation of Deductible, Copayment and Coinsurance amounts for Out-of-Network Providers and Facilities toward your Out-of-Pocket Expense Limits. However, the 25% reduction in the amount paid by Your Health Plan does not count toward your Out-of-Pocket Expense Limits.

The exception to this is the Balance Billing Protection for Out-of-Network Services in the Commonwealth of Virginia (see General Rules Governing Benefits Section)

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BALANCE BILLING PROTECTION FOR OUT-OF-NETWORK SERVICES

Starting January 1, 2021, Virginia state law may protect you from "balance billing" when you get:

- ***EMERGENCY SERVICES*** from an out-of-network hospital, or an out-of-network doctor or other medical provider at a hospital; or
- ***NON-EMERGENCY SURGICAL OR ANCILLARY SERVICES*** from an out-of-network lab or health care professional at an in-network hospital, ambulatory surgical center or other health care facility.

What is balance billing?

- An **"IN-NETWORK"** health care provider has signed a contract with your health insurance plan. Providers who haven't signed a contract with your health plan are called **"OUT-OF-NETWORK"** providers.
- In-network providers have agreed to accept the amounts paid by your health plan after you, the patient, has paid for all required cost sharing (copayments, coinsurance and deductibles for covered services).
- But, if you get all or part of your care from out-of-network providers, you could be billed for the difference between what your plan pays to the provider and the amount the provider bills you. This is called "balance billing."
- The new Virginia law prevents certain balance billing, ***but it does not apply to all health plans.***

Applies	May Apply	Does Not Apply
○ Fully insured managed care plans, including those bought through HealthCare.gov ○ The state employee health plan ○ Group health plans that opt-in	○ Employer-based coverage ○ Health plans issued to an employer outside Virginia ○ Short-term limited duration plans	○ Health plans issued to an association outside Virginia ○ Health plans that do not use a network of providers ○ Limited benefit plans

How can I find out if I am protected?

Be sure to check your plan documents or contact your health plan to find out if you are protected by this law. When you schedule a medical service, ask your health care provider if they are in-network. Insurers are required to tell you (on their websites or on request) which providers are in their networks. Hospitals and other health care providers also must tell you (on their websites or on request) which insurance plans they contract with as in-network providers. Whenever possible, you should use in-network providers for your health care to avoid paying more.

After you receive medical services, your health plan will send you an "Explanation of Benefits" (EOB) that will tell you what you must pay the provider. Save the EOB and check that any bills you receive are not more than the amount listed.

When you *cannot* be balance billed:

If the new law applies to your health plan, an out-of-network provider can no longer balance bill or collect more than your plan's in-network cost-sharing amounts for either (1) emergency care or (2) when you receive lab or professional services (like surgery, anesthesiology, pathology, radiology, and hospitalist services) at an in-network facility.

What should I know about these situations?

Your cost-sharing amount will be based on what your plan usually pays an in-network provider in your area. These payments must count toward your in-network deductible and out-of-pocket limit. If the out-of-network provider collects more than this from you, the provider must refund the excess with interest.

Exception: If you have a high deductible health plan with a Health Savings Account (HSA) or a catastrophic health plan, you must pay any additional amounts your plan is required to pay to the provider, up to the amount of your deductible.

What if I am billed too much?

If you are billed an amount more than your payment responsibility shown on your EOB, or you believe you've been wrongly billed, you can file a complaint with the State Corporation Commission's (SCC) Bureau of Insurance.

To contact the SCC for questions about this notice visit: scc.virginia.gov or call: 1-877-310-6560.