COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

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Important Changes to Your Health Benefits Plan Coverage

Dear Member:

Enclosed is the Notification of Changes to your ***COVA Care Member Handbook*** that became effective July 1, 2017. Also included are some clarifications to existing benefits. The complete COVA Care Member Handbook, including these changes and clarifications, may be found at **www.dhrm.virginia.gov.**

Thank you.

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COVA Care

Commonwealth of Virginia Health Benefits Program
Notification of Changes to Your
COVA Care Member Handbook – July 2016
Effective July 1, 2017

Keep this notification with your COVA Care Member Handbook. 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 including this update from the DHRM Web site at **www.dhrm.virginia.gov**.

Revised language is in bold.

I. PROGRAMS INCLUDED IN YOUR HEALTH PLAN

Add the following benefit provisions

LiveHealth Online - (Page 97)

In addition to a face-face doctor Visit from your mobile device or computer, you may use LiveHealth Online to talk with a counselor at no cost as part of your EAP benefit. Call 1-855-223-9277 to get your coupon code and instructions on how to make your first appointment.

You may also make an appointment with a licensed therapist with LiveHealth Online Psychology. Schedule online at www.livehealthonline.com or call 1-844-784-8409 to make an appointment. Cost is the same as an outpatient behavioral health office visit.

Employee Assistance Program (EAP) - (Page 98)

Included with your EAP is the MyStrength online tool, a free resource to help you and your family members deal with chronic pain, depression, substance abuse and anxiety.

II. EXCLUSIONS

Remove the following exclusions to comply with Affordable Care Act (ACA) Section 1557, Nondiscrimination in Health Programs and Activities

- Behavioral Health – remove exclusion for sexual dysfunction and sex transformation (Page 99)

- Gender Reassignment – remove exclusion for services for gender reassignment (sex transformation). This includes Medical, Behavioral Health and Outpatient Prescription Drug services (Page 102)

- Surgery for Sexual Dysfunction – remove exclusion for surgeries for sexual dysfunction (Page 106)

Following are <u>Clarifications</u> to existing benefit provisions. These do not represent any changes in benefits.

III. DEFINITIONS

Out-of-Pocket Expense Limit - (Page 18)

Family Limit on Out-of-Pocket Expenses
The Out-of-Pocket Expense Limit is calculated on an individual basis for each family member. This is how the Out-of-Pocket Expense Limit works for each coverage type:

You Only: If you have single-only coverage, you are responsible for satisfying the single Out-of-Pocket Expense Limit only.

You and One Family Member: Each of you must satisfy the individual Out-of-Pocket Expense Limit.

Family: Out-of-Pocket Expense Limit amounts for each individual member accumulate toward the family Out-of-Pocket Expense Limit. However, no individual family member can contribute more than the single-only Out-of-Pocket Expense Limit amount.

IV. GENERAL RULES GOVERNING BENEFITS

10) Complaint and Appeal Process

Other Appeals to DHRM - (Page 31)

DHRM does not accept appeals for matters in which the sole issue is disagreement with policies, rules, regulations, contract or law. If you are unsure whether an eligibility determination can be appealed, call the Office of Health Benefits at 804-225-3642 or 888-642-4414.

13) Out-of-Pocket Expense Limit - (Page 33)

Expenses that do not count toward your Out-of-Pocket Expense Limit:
- the difference between the Allowable Charge for a brand name outpatient prescription drug and the Allowable Charge for its generic equivalent;

19) Voluntary Health Services Review - (Page 34)

For surgical services, it is recommended, **especially for high cost services**, that you have your Provider call Anthem to see if the service is covered in advance of receiving services and it's your responsibility to ensure the review has been done. You can also request a voluntary Health Services Review directly with Anthem. If you sign a financial waiver from the Provider or hospital then you may be responsible for services not covered by the health Plan Administrator.

21) **Clinical Trial Costs** – (Page 36)
All requests for clinical trial services, including requests that are not part of approved clinical trials, will be reviewed according to our Clinical Coverage Guidelines related policies and procedures.

V. PROFESSIONAL SERVICES

Conditions for Reimbursement – (Page 50)

8) It is recommended, **especially for high cost services**, that you have your Provider call the Plan Administrator to determine if the service is covered in advance of receiving services, and it is your obligation to check with your Provider to make sure the review has been done. You can also request a voluntary Health Services Review directly with the Plan Administrator. If you sign a financial waiver from the Provider or hospital then you may be responsible for services not covered by Your Health Plan.

VI. WELLNESS AND PREVENTIVE CARE SERVICES - (Page 57)

Services Which Are Eligible for Reimbursement

Child Wellness and Preventive Care

The following generic prescription strength over-the-counter (OTC) products are covered, and require a prescription from a Provider:

- Fluoride supplements for children from birth through **6** years old

Adult Wellness and Preventive Care

The following generic prescription strength over-the-counter (OTC) products are covered, and require a prescription from a Provider:

- **Low-dose aspirin (81mg) for pregnant women who are at increased risk of preeclampsia**
- Folic acid (.4mg -.8mg) for women through age **55**

VII. OUTPATIENT PRESCRIPTION DRUGS - (Page 74)

Health Plan Reimbursement

1) Your Health Plan pays the remaining Allowable Charge after you pay the Copayment or Coinsurance. The Plan Administrator will determine whether a particular generic Outpatient Prescription Drug is equivalent to a brand name Outpatient Prescription Drug. If you or your Provider determine to fill the prescription with a brand name drug when a generic equivalent is available, you will be responsible not only for the brand Copayment, but also the difference between the Allowable Charge for the brand name drug and the Allowable Charge of its generic equivalent. **The difference between the Allowable Charge for the**

brand name drug and the Allowable Charge of its generic equivalent does not count towards the medical Out-of-Pocket Expense Limit. There is a maximum member cost each time a member purchases a brand name drug when a generic is available in the immunosuppressant, anticonvulsant, and psychotherapeutic drug categories.

VIII. BLUECARD PROGRAM PLAN - (Page 92)

Update the following information in this section:

Name of BlueCard Worldwide® for Care outside the United States is changed to **Blue Cross Blue Shield Global Core.**

Web address is changed to: www.bcbsglobalcore.com

There is no change to the Service Center telephone numbers. Call the **Blue Cross Blue Shield Global Core Service Center** toll free at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

IX. PROGRAMS INCLUDED IN YOUR HEALTH PLAN – (Page 96)

Update the following information in this section:

MyActiveHealth

Name of Personal Health Alerts – Care Considerations is changed to **Personal Health Alerts – Healthy Action**.

X. ELIGIBILITY, ENROLLMENT AND CHANGES - (Page 114)

Incapacitated Dependents
The child must live **full-time** with the employee as a member of the employee's household, not be married, and be dependent upon the employee for financial support.

Adding Adult Incapacitated Dependents as a Qualifying Mid-Year Event
Eligibility rules require that the incapacitated dependent live **full-time** at home, is not married, and receives over one-half of his or her financial support from the employee.