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Important Changes to Your Health Benefits Plan Coverage

Dear Member:

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

Thank you.

A10346 (Eff. 1/1/2021)

COVA HealthAware

Commonwealth of Virginia Health Benefits Program
Amendment/Notification of Changes to Your
July 2019 COVA HealthAware Member Handbook
Effective January 1, 2021

Keep this notification with your COVA HealthAware Member Handbook and previous Amendments. These notifications and your member handbook constitute a full and complete description of your coverage. You also may view or download the COVA HealthAware Member Handbook and all Amendments from the DHRM Website at **www.dhrm.virginia.gov**.

Changes are in *bold italic* type. All other information is for clarification.

Benefit Basics Section – It's Your Choice (page 22-23)

When you need care, you have a choice. You can select a doctor, behavioral health provider or facility that participates in the network (an in-network provider) or one that does not participate (an out-of-network provider).

- *If you use an in-network provider*, you'll usually pay less out of your own pocket for your care. You won't have to fill out claim forms because your in-network provider will file claims for you. In addition, your provider will make the necessary telephone call to start the precertification process when you must be hospitalized or need certain types of care. (See Precertification for more information.)
- *If you use an out-of-network provider,* you'll usually pay more out of your own pocket for your care. You may be required to file your own claims and you must make the telephone call if you want to get precertification of the services. (See Claims and Appeals and Precertification for more information.)

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

When you receive emergency services from an out-of-network healthcare 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.

Your Plan at a Glance shows how the Plan's level of coverage differs when you use in-network versus out-of-network providers. In most cases, you save money when you use in-network providers.

Add a new section after CHIPRA section (page 142)

Form 405-A (eff. 1/2021)

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.

The following change is effective July 1, 2021

Prescription Drugs Section – Covered Drugs (page 71)

4) The following items for the treatment of diabetes:
   - blood glucose meters;
   - blood glucose test strips;
   - ***continuous glucose monitors***
   - hypodermic needles and syringes;
   - insulin; and
   - lancets.

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