JANET L. LAWSON
DIRECTOR

COMMONWEALTH OF VIRGINIA

Department Of Human Resource Management

James Monroe Building
N. 14th Street, 12th Floor
Richmond, Virginia 23219
Tel: (804) 225-2131
(TTY) 711

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 July 1, 2022. The COVA Care Member Handbook, and this Amendment, may be found at **www.dhrm.virginia.gov**.

Thank you.

A10614 (Eff. 7/1/2022)

COVA Care

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

Effective July 1, 2022

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)

Intensive In-Home Services
Intensive In-Home services are concentrated, time-limited interventions provided typically but not solely in the residence of a member **considered to be at high risk for hospitalization, re-hospitalization, or other types of facility-based services, due to severe behavioral health disorders and behaviors**. Services provide crisis treatment; individual and family counseling; and communication skills (e.g., counseling to assist a child and his parents to understand and practice appropriate problem-solving, anger management, and interpersonal interaction, etc.); case management activities and coordination with other required services; and 24-hour emergency response. Services must be provided by a provider practice licensed by the Department of Behavioral Health and Developmental Services. Clinical supervision of intensive in-home services must be provided by an independently licensed provider face-to-face and occur weekly.

II. PROFESSIONAL SERVICES – (Page 54)

Behavioral Health and Employee Assistance Program Services

Services Which Are Eligible for Reimbursement

8) Intensive In-Home Services

Intensive In-Home Services includes but is not limited to the following:
- crisis treatment;
- individual and family counseling;
- counseling to assist the **member and parents/household members as appropriate** to understand and practice appropriate problem solving, anger management, and personal interaction;
- case management activities and coordination with other required services; and
- 24-hour emergency response.

III. OTHER COVERED SERVICES – (Page 68)

Services Which Are Eligible for Reimbursement

6) Covered diabetic equipment includes:
   - insulin pumps and associated supplies;
   - lancet devices; and
   - calibrator solution.

IV. OUTPATIENT PRESCRIPTION DRUGS – (Page 72)

Administered by Anthem Pharmacy, delivered by IngenioRx

Services Which are Eligible for Reimbursement

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

Special Limits

13) Benefits for **Continuous Glucose Monitors (CGMs)** through a network retail pharmacy require a prescription and will apply to the standard benefit Copayment based on tier.

V. Programs Included In Your Health Plan – (Page 98)

Healthy Smile, Healthy You®
Administered by Delta Dental of Virginia

Growing evidence confirms the connection between oral health and overall general health. Delta Dental of Virginia's *Healthy Smile, Healthy You®* program provides additional benefits for **six** important health conditions connected to oral health: pregnancy, diabetes, high risk cardiac conditions, **cancer treatment, weakened immune system, and kidney failure or dialysis**.

- Pregnant members enrolled in the Future Moms program are eligible for **fluoride applications beyond the age limitation**, one additional Dental cleaning and exam, or periodontal maintenance visit (if the member has a history of periodontal surgery) during the term of their pregnancy, in addition to the normal plan frequency limits. **Members enrolled in the Future Moms program will be automatically enrolled in Healthy Smile, Healthy You®.**

- Diabetic, High Risk Cardiac members enrolled in the ConditionCare program are eligible for one additional Dental cleaning and exam, or periodontal maintenance Visit (if the member has a history of periodontal surgery) during the Plan Year.

Members enrolled in the ConditionCare program will be automatically enrolled in Healthy Smile, Healthy You®.

- **Members undergoing cancer treatment, have weakened immune systems, and/or have kidney failure or dialysis are eligible for fluoride applications beyond the age limitation, one additional Dental cleaning and exam, or periodontal maintenance Visit (if the member has a history of periodontal surgery) during the Plan Year. These conditions require a separate form to be completed by your physician, which can be found on the Members page at DeltaDentalVA.com (www.deltadentalva.com/members).**

See the information in this section on enrolling in the Future Moms or ConditionCare programs.

TeleDentistry.com Virtual Dental Visits
Administered by Delta Dental of Virginia

To increase access to care when you most need it, Delta Dental of Virginia includes access to teledentistry services with your existing dental plan*. Members can use Delta Dental – Virtual Visits when they:
- **Have a dental emergency and do not have a dentist;**
- **Need access to a dentist after hours;**
- **Need to consult a dentist without leaving home or while traveling.**

Members can conveniently access the teledentistry service by a smartphone, tablet or computer with audiovisual capabilities. Or members may call the dedicated phone number at 866-256.2101.

TeleDentistry.com dentists provide the initial consultation and can write prescriptions when appropriate. After the initial consultation, the TeleDentistry.com dentist will email consultation notes to the member's Participating (Par) Dentist for further treatment. If the member has not established care with a Par Dentist, TeleDentistry.com will refer them to one.**

***TeleDentistry.com services are only available to current Delta Dental of Virginia members.**

A TeleDentistry.com consultation counts as a problem-focused exam (D0140) under your dental plan.

****E-prescriptions are not available internationally through TeleDentistry.com.**

Live Health Online
Administered by Anthem

LHO Healthy Sleep - Provides members with a home sleep evaluation in a virtual environment, where sleep specialists diagnose sleep disorders and design treatment plans to improve sleep and overall health.

Employee Assistance Program (EAP)
Administered by Anthem

Your EAP includes **access to digital emotional well-being resources to help you better manage stress, depression, anxiety, substance use, and/or sleep issues. Visit www.anthemeap.com and click on the 'Emotional Well-Being Resources' box to access these valuable tools.**

Personal Care Checklist
Administered by Anthem

The Personal Care Checklist is a personalized and claims-based email communication from Anthem, that encourages members to see their doctor for an annual wellness visit, to get recommended preventive screenings, to get tests to help manage chronic diseases, and to encourage medication review and adherence. Only members whose claims show that they are overdue for one of these activities will receive an email with up to four personalized recommendations and a reminder to contact their doctor. Depending on each member's specific needs, email messaging may include reminders for things like:

- **Scheduling wellness exams**
- **Screenings for cervical, colon or breast cancer**
- **A1C, kidney function or blood pressure checks**

VI. Eligibility, Enrollment and Changes – (Page 117)

Qualifying Mid-Year Events (Changes Outside Open Enrollment)
The term **Life Events** refers to Qualifying Mid-Year Events (QME), which permit specific election changes outside the Open Enrollment period, including changes to your plan and membership. **Life Events** and Qualifying Mid-Year Events may be used interchangeably.

Special Enrollment Provisions for Birth, Adoption or Placement for Adoption
An exception to prospective changes is health plan coverage for newborns, adopted children, and those children placed for adoption. In these events, health plan coverage will be retroactive to the date of birth, adoption or placement for adoption.

When making health plan changes and adding eligible dependents for Birth, Adoption or Placement of Adoption, those changes are effective the first of the month of the birth.

For all health plan changes due to birth, adoption or placement for adoption, the new premiums are due for the full month of coverage.

VII. Other Federal Notices – (Page 143)

Virginia Balance Billing Protection for Out-of-Network Services – see attached

Federal Balance Billing Protection for Out-of-Network Services – see attached

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network facility, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

Insurers are required to tell you which providers and facilities are in their networks. Providers and facilities must tell you with which provider networks they participate. This information is on the insurer's, provider's or facility's website or on request.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as deductibles, copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services at the same facility that you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network facility

When you get services from an in-network facility, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, laboratory, surgeon and assistant surgeon services, and professional ancillary services such as anesthesia, pathology, radiology, neonatology, hospitalist, or intensivist services. These providers **can't** balance bill you and **can't** ask you to give up your protections not to be balance billed.

If you receive other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and in-network out-of-pocket limit.

If you believe you've been wrongly billed, you may call the federal agencies responsible for enforcing the federal balance billing protection law at: **1-800-985-3059** and/or file a complaint with the Virginia State Corporation Commission Bureau of Insurance at: scc.virginia.gov/pages/File-Complaint-Consumers or call **1-877-310-6560**.

Visit cms.gov/nosurprises for more information about your rights under federal law.

Consumers covered under (i) a fully-insured policy issued in Virginia, (ii) the Virginia state employee health benefit plan; or (iii) a self-funded group that opted-in to the Virginia protections are also protected from balance billing under Virginia law. Visit scc.virginia.gov/pages/Balance-Billing-Protection for more information about your rights under Virginia law.

Federal Balance Billing Protection for Out-of-Network Services

Your rights and protections against surprise medical bills

When you receive emergency care or are treated by an out-of-network doctor or specialist at a hospital or ambulatory surgical center in your plan's network, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you visit a doctor or other healthcare specialist, you may owe certain out-of-pocket costs, such as a copay, coinsurance, and/or a deductible. If you visit a doctor or specialist or visit a healthcare facility that isn't in your health plan's network, you might owe additional charges or be responsible for the entire bill.

"Out-of-network" describes doctors and healthcare facilities that haven't signed a contract with your health plan. Out-of-network doctors and facilities may be allowed to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing.**" This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care —like when you have an emergency or when you schedule a visit at a facility in your plan's network but are unexpectedly treated by an out-of-network doctor.

You are protected from balance billing for:

Emergency services

If you have an emergency medical situation and receive emergency services from an out-of-network doctor or facility, the most the doctor or facility may bill you is your plan's in-network cost-sharing amount (such as copays and coinsurance). You **cannot** be balance billed for these emergency services. This includes services you may receive after you're in stable condition, unless you give written consent to give up your protections against balance billing once you're stable.

Certain services at a hospital or ambulatory surgical center in your plan's network

When you receive services from a hospital or ambulatory surgical center (places that perform outpatient surgeries) in your plan's network, certain doctors or specialists there may be out-of-network. In these cases, the most they may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These specialists **cannot** balance bill you and cannot ask you to give up your protections not to be balance billed.

If you receive other services at these in-network facilities, out-of-network doctors or other healthcare professionals **cannot** balance bill you, unless you give written consent to give up your protections.

You're <u>never</u> required to give up your protections against balance billing. You also aren't required to receive care out of your plan's network. You can use the Find Care tool on our website to find doctors and hospitals in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copay, coinsurance, and deductibles that you would pay if the doctor or facility was in your plan's network). Your health plan will pay out-of-network doctors and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (also called prior authorization).
    - Cover emergency services by out-of-network doctors or specialists.
    - Base what you owe the doctor or facility (cost-sharing) on what it would pay a doctor or facility in your plan's network and show that amount in your explanation of benefits.

- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you think you've been wrongly billed, you can contact the Employee Benefits Security Administration (EBSA), the No Surprise Help Desk (NSHD) at 1-800-985-3059 or cms.gov/nosurprises or your State Regulator, if your plan is fully insured, to ask whether the charges are allowed by law.