Transparency In Coverage

What does transparency in coverage mean?

All insurance companies are required by law to make accurate and timely disclosures of transparency reporting information for their Individual and Family Medical insurance plans. This webpage is an outline of important medical coverage information. If you have a question about your Virginia Premier Individual plan, please contact our Member Services number at (833) 672-8075 for additional information (TTY users should dial 711.) Member Services has free language interpreter services available for non-English speakers. You may also visit our website at www.virginiapremier.com/individual-family. Product details for Virginia Premier Individual plans vary based on the plan. Read the plan information and policy disclosures, including exclusions and limitations that apply to the policy you are interested in purchasing before you apply for coverage.

Virginia Premier's HMO Plans

Out-of-Network Liability and Balance Billing

If you choose one of Virginia Premier's HMO plans, the highest level of benefits is available when you obtain covered services from Virginia Premier providers. The benefits are called "in-network" benefits. If you receive covered services from providers other than Virginia Premier providers, you will be subject to a reduced level of benefits (which may result in no benefits for some services). These reduced benefits are called "out-of-network" benefits. Coverage for both "in-network" and "out-of-network" benefits is described on the Schedule of Benefits that is a part of your Policy.

You have the option to receive services from Virginia Premier or non-Virginia Premier providers. When you choose to receive services from a non-Virginia Premier provider, then you are considered "out-of-network." You have access to the same covered services as provided in this Policy; however, different copayment, deductible and/or coinsurance amounts or benefits maximums are listed on your Schedule of Benefits for out-of-network services that will apply. If you receive services without the proper authorization, you are considered "out-of-network." Refer to your plan documents for important benefit information.

The copayment amounts and coinsurance percentages for emergency services received from a non-Virginia Premier provider are the same as the copayment amounts and coinsurance percentages for emergency services received from a Virginia Premier provider. Medically necessary services will be covered whether you get care from an in-network or out-of-network provider. Emergency care you get from an out-of-network provider will be covered as an in-network service, but you may have to pay the difference between the out-of-network provider's charge and the maximum allowed amount, as well as any applicable coinsurance, copayment or deductible.

If you choose one of Virginia Premier's HMO plans, there are no benefits provided for out-of-network services, except in cases of emergency services or in cases where Virginia Premier has issued an authorization. This means that if you go to an out-of-network provider, without having a Virginia Premier authorization or being an emergency situation, you will have to pay all charges out of pocket for the services you receive.

When you receive care or treatment from a non-Virginia Premier provider, you may be responsible for all claims filing and prior authorization if this provider does not agree to do so on your behalf. In addition, you may be balance billed by non-Virginia Premier providers as described below.

Balance Billing - Virginia Premier's payment for covered services is based on an allowable charge. When services are received from a Virginia Premier provider who has agreed to Virginia Premier's negotiated rate, participants are not responsible for the difference between the negotiated rate and the billed amount. This amount is "written off" by the Virginia Premier Provider. For out-of-network covered services, the benefit payable is based on an allowable charge that Virginia Premier has determined to be applicable to non-Virginia Premier providers. Balance billing is when the non-Virginia Premier Provider bills you for the amounts over and above Virginia Premier's allowable charge. You are responsible for the amounts above the allowable charge in addition to any copayment, deductible and/or coinsurance amounts. Balance billed amounts do not count towards the out-of-pocket limit maximum.

Allowable charge means the amount determined by Virginia Premier as payable for a specified covered service or the provider's actual charge for that service, whichever is less. Virginia Premier will not pay more than its allowable charge for any covered service. You will only have to pay your copayment, deductible, and/or coinsurance and will not be balance billed by Virginia Premier providers for amounts above the allowable charge. When seeing a non-Virginia Premier provider due to a Virginia Premier preauthorized referral or an emergency, participants are responsible for billed charges in excess of the allowable charge. Amounts above the allowable charge do not apply toward the maximum out-of-pocket limit.

Enrollee Claims Submission

Virginia Premier in-network providers will file claims for you after you receive services. When you receive care or treatment from a non-Virginia Premier provider, you may be responsible for all claims filing and prior authorization if this provider does not agree to do so on your behalf. In addition, you may be balance billed by non-Virginia Premier providers.

If you receive out-of-plan services, you must submit your claims within 180 days from the date services are received. To file a claim, follow these 3 steps:

1. Call Member Services at (833) 672-8075 to order a claim form.

2. Complete and sign the claim form. Attach all itemized bills for covered services. Each itemized bill must contain the following:
    - name and address of the person or organization providing services or supplies;
    - name of the patient receiving services or supplies;
    - date services or supplies were provided;
    - the charge for each type of service or supply;
    - a description of the services or supplies received; and
    - a description of the patient's condition (diagnosis).

3. Send the completed claim form and itemized bill(s) to:
   Virginia Premier
   Attention: Claims
   P.O. Box 106020
   Pittsburgh, PA 15230-6019

Grace Periods and Claims Pending Policies During the Grace Period

If you do not pay the full amount of your premium by the premium due date, a grace period is triggered. The grace period is an additional period of time during which coverage may remain in effect and refers to either a 3-month grace period required for individuals receiving advance payments of the premium tax credit (APTC) or for individuals not receiving the APTC; it refers to any other applicable grace period.

If you do not pay the required premium by the end of the grace period, your coverage is terminated. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted.

If your claim is not approved or denied it is referred to as pending.

Grace Period with Advanced Premium Tax Credit

If you are receiving the APTC and have previously paid at least one month's premium in a benefit year, Virginia Premier will provide a grace period of at least three consecutive months. During the grace period, Virginia Premier will apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If full premium payment is not received during the grace period, the last day of coverage will be the last day of the first month of the 3-month grace period. Virginia Premier will pay claims during the first month of the grace period, but may pend claims in the second and third months subject to the plan's right to terminate your coverage, as provided herein. You will be liable to Virginia Premier for the premium payment due including those for the grace period. You will also be liable to Virginia Premier for any claims payments made for services incurred after the last day of the first month of the 3-month grace period.

Grace Period without Advanced Premium Tax Credit

If are not receiving an APTC, you have a grace period of 31 days. This means if any premium payment, except the first, is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, your coverage will stay in force unless prior to the date premium payment is due, you give timely written notice to us that your coverage is to be terminated. If you do not make the full premium payment during the grace period, your coverage will be terminated on the last day of the grace period. You will be liable to us for the premium payment due including for the grace period. You will also be liable to us for any claims payments made for services incurred after the last day of the grace period.

Retroactive Denials

Virginia Premier may deny a claim after you have received services from a provider. This could happen in cases of loss of coverage due to non-payment of premium or loss of eligibility of coverage. It could also occur if Virginia Premier performs a retrospective review of medical

records or services to determine medical necessity. A retrospective review could also include determining that a true emergency situation existed for emergency room or urgent care center visits.

You should try to prevent retroactive denials of claims by always paying you premiums on time and notifying the Marketplace of any change in circumstances. You should also become familiar with Virginia Premier's prior authorization procedures to prevent retroactive denials. Additionally, present your ID card when you receive services and make sure your provider has your current insurance information.

Recoupment of Overpayments

If you overpaid your insurance premium you may qualify for a refund. You should contact Virginia Premier if you think that you have paid more premium than what you believe is due and therefore ask Virginia Premier for a refund.

Medical Necessity and Prior Authorization Timeframes and Enrollee Responsibilities

Medically necessary services or medical necessity refers to those covered services that Virginia Premier determines are: 1) required to identify or treat an illness, injury, or pregnancy-related condition, 2) consistent with the symptoms or diagnosis and treatment of your condition, 3) in accordance with standards of generally accepted medical practice, and 4) the most suitable supply or level of service that can safely treat the condition and not be for the convenience of the patient, patient's family, or the provider. Virginia Premier will determine the medical necessity of a given service or procedure.

It is your responsibility to obtain prior authorization before treatment is received for services that require it. Virginia Premier requires providers (or participants acting on their own behalf) to make prior authorization arrangements during regular business hours. Virginia Premier's prior authorization is not required for emergencies anytime or urgent care situations after hours.

Certain covered services will require prior authorization by Virginia Premier, except in an emergency or urgent Care situations after hours (see below). Your Virginia Premier physician will work with you and Virginia Premier to handle these prior authorization requirements. Examples of these services are as follows:

1. Inpatient admission
2. Certain outpatient procedures and services
3. Certain drugs and medications

Typically, in-network providers know which services need prior authorization and will get any prior authorization when needed. Your primary care physician and other in-network providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering provider, facility or attending doctor ("requesting provider") will get in touch with us to ask for a prior authorization review.

However, you may request a prior authorization, or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be

anyone who is 18 years of age or older. We will still require clinical information from your provider to determine medical necessity.

Prior authorization is not required to receive emergency care. For emergency care admissions, you, your authorized representative or doctor must tell us within one (1) business day of the admission, or as soon as possible, within a reasonable period of time.

A plan participant is not required to receive a referral or authorization from their primary care physician before receiving obstetrical or gynecological care from an in-network provider specializing in obstetrics or gynecological care.

Drug Exceptions Timeframes and Enrollee Responsibilities

Virginia Premier has a process in place for you, a designated representative, the prescribing physician or other prescriber to request and gain access to clinically appropriate drugs not otherwise covered on Virginia Premier's formulary.

Standard Request

If you or your doctor believes you need a prescription drug due that is not on the prescription drug list, please have your doctor or pharmacist get in touch with us. Virginia Premier will act upon such requests within one (1) business day of receipt of the request. Virginia Premier will cover the prescription drug only if we agree that it is medically necessary and appropriate over the other drugs that are on the list. Virginia Premier will make a coverage decision within 72 hours of receiving your request.

If Virginia Premier approves the coverage of the drug, coverage of the drug will be provided for the duration of your prescription, including refills. If we deny coverage of the drug, you have the right to request an independent external review with the agency described in the external review provision of your plan documents.

Expedited Request

You or your doctor may also submit a request for a prescription drug that is not on the prescription drug list based on exigent circumstances. Exigent circumstances exist if you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a drug not covered by the plan. Virginia Premier will make a coverage decision within 24 hours of receiving your request. If we approve the coverage of the drug, coverage of the drug will be provided for the duration of the exigency. If we deny coverage of the drug, you have the right to request an independent external review with the agency described in the external review provision of your plan documents. The independent external reviewer will make a coverage decision within 24 hours of receiving your request. If the independent external reviewer approves the coverage of the drug, coverage of the drug will be provided for the duration of the exigency.

Information on Explanation of Benefits (EOBs)

Virginia Premier will provide an Explanation of Benefits (EOB) document to you after you receive a service. The EOB will provide details on the following items concerning the health care service:

- Virginia Premier contact information if you have any questions;
- Claim detail to explain what medical treatments and/or services were paid; it tells you

how your claim was paid, including the amount that was paid and to whom it was paid.

Coordination of Benefits (COB)

Coordination of Benefits (COB) provisions apply when you are covered by more than one health insurance plan. When the COB provision applies, the insurance carriers involved will coordinate the benefits payable. The purpose of the COB provision is to save health care dollars by preventing duplicate payments for the same services. Please refer to your policy for more information within the 'If You Are Covered By More Than One Policy' section.