

Summary of Material Modifications to the UVA Health Plan in 2020 due to the COVID-19 pandemic

- Beginning March 17, 2020, the UVA Health Plan covers Teladoc visits for general medicine, behavioral health care services, dermatology, and caregiving. Due to the COVID-19 pandemic, there is no participant costsharing for Teladoc or telemedicine visits from March 17 – June 4, 2020. The UVA Health Plan covers these visits at 100%. Beginning June 5, 2020, the costsharing for Teladoc or telemedicine visits is the same as those used for in-network on-site PCP office visits. Those are:
 - Deductible + 15% coinsurance for Choice Health
 - Deductible + 20% coinsurance for Basic Health
 - PCP copayment for Value Health
- Teladoc and telemedicine visits return to their standard costsharing beginning June 5, 2020.
- Temporary additions to the approved telemedicine visits due to COVID-19 will be covered through December 31, 2020.

- FDA-approved testing needed to detect or diagnose COVID-19 and the administration of that testing is classified as a preventive diagnostic test beginning March 18, 2020. The UVA Health Plan covers it at 100%. There is no participant costsharing.

- Services furnished during visits that result in an order for, or administration of, a COVID-19 diagnostic test, but only to the extent that the items or services relate to the furnishing or administration of the test or the evaluation of the participant for purposes of determining the need of the participant for the product will be covered by the UVA Health Plan at 100%. There is no participant costsharing.

- From March 17 – December 31, 2020, the UVA Health Plan will waive costsharing for in-network COVID-19-related medical treatment. This covers the cost of in-network care for patients who are admitted to the hospital for COVID-19 treatment.

- Timeframes have been extended with respect to the period from March 1, 2020 until 60 days after the announced end of the National Emergency period (or a later date announced in subsequent guidance from the Departments of Labor and Treasury). That period is referred to as the “Outbreak Period” and will be disregarded when calculating deadlines related to HIPAA special enrollments, COBRA, and claims and appeals extensions. Actions required to be taken during the Outbreak Period are extended until after the Outbreak Period ends.
 - HIPAA special enrollment period: requests to add a new dependent due to birth, adoption, marriage, divorce, or loss of eligibility for other health coverage for events that occurred during the Outbreak Period will be accepted with the required documentation up to 30 days after the end of the Outbreak Period. Requests to add or drop dependents due to eligibility/loss of S-CHIP or Medicaid will be accepted with the required documentation up to 60 days after the end of the Outbreak Period.
 - COBRA election period: requests to enroll in COBRA after a qualifying event that occurred during the Outbreak Period will be accepted up to 60 days after the end of the Outbreak Period.
 - COBRA premium payment periods: initial premium payments due during the Outbreak Period will be accepted up to 45 days after the end of the Outbreak Period. The grace period for subsequent premium payments due during the Outbreak Period will be accepted up to 30 days after the end of the Outbreak Period.
 - COBRA notices from participants: notification of a COBRA qualifying event by the participant that occurred during the Outbreak Period will be accepted up to 60 days after the end of the Outbreak Period.
 - COBRA election notices: group plan notices to participants who experienced a qualifying event during the Outbreak Period will be provided up to 44 days after the end of the Outbreak Period.
 - Deadlines for filing a benefit claim, filing an appeal of an adverse benefit determination, filing an external review request, and submitting additional information related to an external review: the filing deadlines will be extended by disregarding the Outbreak Period when calculating the participant’s deadline.