

1 HOUSE BILL NO. 601
 2 AMENDMENT IN THE NATURE OF A SUBSTITUTE
 3 (Proposed by the House Committee on Labor and Commerce
 4 on _____)
 5 (Patron Prior to Substitute--Delegate Kilgore)

6 A BILL to amend and reenact §§ 38.2-3412.1, 38.2-3438, and 38.2-3445 of the Code of Virginia, relating
 7 to health insurance; emergency services; mobile crisis response services.

8 **Be it enacted by the General Assembly of Virginia:**

9 **1. That §§ 38.2-3412.1, 38.2-3438, and 38.2-3445 of the Code of Virginia are amended and reenacted**
 10 **as follows:**

11 **§ 38.2-3412.1. Coverage for mental health and substance use disorders.**

12 A. As used in this section:

13 "Adult" means any person who is 19 years of age or older.

14 "Alcohol or drug rehabilitation facility" means a facility in which a state-approved program for
 15 the treatment of alcoholism or drug addiction is provided. The facility shall be either (i) licensed by the
 16 State Board of Health pursuant to Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 or by the Department of
 17 Behavioral Health and Developmental Services pursuant to Article 2 (§ 37.2-403 et seq.) of Chapter 4 of
 18 Title 37.2 or (ii) a state agency or institution.

19 "Child or adolescent" means any person under the age of 19 years.

20 "Crisis receiving center" means a community-based facility licensed by the Department of
 21 Behavioral Health and Developmental Services to provide short-term assessment, observation, and crisis
 22 stabilization services.

23 "Inpatient treatment" means mental health or substance abuse services delivered on a 24-hour per
 24 day basis in a hospital, alcohol or drug rehabilitation facility, an intermediate care facility or an inpatient
 25 unit of a mental health treatment center.

26 "Intermediate care facility" means a licensed, residential public or private facility that is not a
27 hospital and that is operated primarily for the purpose of providing a continuous, structured 24-hour per
28 day, state-approved program of inpatient substance abuse services.

29 "Medication management visit" means a visit no more than 20 minutes in length with a licensed
30 physician or other licensed health care provider with prescriptive authority for the sole purpose of
31 monitoring and adjusting medications prescribed for mental health or substance abuse treatment.

32 "Mental health services" or "mental health benefits" means benefits with respect to items or
33 services for mental health conditions as defined under the terms of the health benefit plan. Any condition
34 defined by the health benefit plan as being or as not being a mental health condition shall be defined to be
35 consistent with generally recognized independent standards of current medical practice.

36 "Mental health treatment center" means a treatment facility organized to provide care and
37 treatment for mental illness through multiple modalities or techniques pursuant to a written plan approved
38 and monitored by a physician, clinical psychologist, or a psychologist licensed to practice in this
39 Commonwealth. The facility shall be (i) licensed by the Commonwealth, (ii) funded or eligible for funding
40 under federal or state law, or (iii) affiliated with a hospital under a contractual agreement with an
41 established system for patient referral.

42 "Mobile crisis response services" means ~~services delivered~~ licensed by the Department of
43 Behavioral Health and Developmental Services to provide for rapid response to, assessment of, and early
44 intervention for individuals experiencing an acute mental health crisis that are deployed at the location of
45 the individual.

46 "Network adequacy" means access to services by measure of distance, time, and average length of
47 referral to scheduled visit.

48 "Outpatient treatment" means mental health or substance abuse treatment services rendered to a
49 person as an individual or part of a group while not confined as an inpatient. Such treatment shall not
50 include services delivered through a partial hospitalization or intensive outpatient program as defined
51 herein.

52 "Partial hospitalization" means a licensed or approved day or evening treatment program that
53 includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities
54 designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence
55 who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall
56 provide treatment over a period of six or more continuous hours per day to individuals or groups of
57 individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs
58 for the treatment of alcohol or other drug dependence which provide treatment over a period of three or
59 more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

60 "Residential crisis stabilization unit" means a community-based, short-term residential program
61 providing licensed by the Department of Behavioral Health and Developmental Services to provide short-
62 term assessment, observation, support, and crisis stabilization for individuals who are experiencing an
63 acute mental health crisis.

64 "Substance abuse services" or "substance use disorder benefits" means benefits with respect to
65 items or services for substance use disorders as defined under the terms of the health benefit plan. Any
66 disorder defined by the health benefit plan as being or as not being a substance use disorder shall be
67 defined to be consistent with generally recognized independent standards of current medical practice.

68 "Treatment" means services including diagnostic evaluation, medical, psychiatric and
69 psychological care, and psychotherapy for mental, emotional or nervous disorders or alcohol or other drug
70 dependence rendered by a hospital, alcohol or drug rehabilitation facility, intermediate care facility,
71 mental health treatment center, a physician, psychologist, clinical psychologist, licensed clinical social
72 worker, licensed professional counselor, licensed substance abuse treatment practitioner, licensed
73 marriage and family therapist or clinical nurse specialist. Treatment for physiological or psychological
74 dependence on alcohol or other drugs shall also include the services of counseling and rehabilitation as
75 well as services rendered by a state certified alcoholism, drug, or substance abuse counselor or substance
76 abuse counseling assistant, limited to the scope of practice set forth in § 54.1-3507.1 or 54.1-3507.2,
77 respectively, employed by a facility or program licensed to provide such treatment.

78 B. Except as provided in subsections C and D, group and individual health insurance coverage, as
79 defined in § 38.2-3431, shall provide coverage for mental health and substance use disorder benefits. Such
80 benefits shall be in parity with the medical and surgical benefits contained in the coverage in accordance
81 with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), P.L. 110-343, even
82 where those requirements would not otherwise apply directly. Coverage required under this subsection
83 shall include mobile crisis response services and support and stabilization services provided in a
84 residential crisis stabilization unit or crisis receiving center to the extent that such services are covered in
85 other settings or modalities, regardless of any difference in billing codes.

86 C. Any grandfathered plan as defined in § 38.2-3438 in the small group market shall either continue
87 to provide benefits in accordance with subsection B or continue to provide coverage for inpatient and
88 partial hospitalization mental health and substance abuse services as follows:

89 1. Treatment for an adult as an inpatient at a hospital, inpatient unit of a mental health treatment
90 center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of 20 days
91 per policy or contract year.

92 2. Treatment for a child or adolescent as an inpatient at a hospital, inpatient unit of a mental health
93 treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period
94 of 25 days per policy or contract year.

95 3. Up to 10 days of the inpatient benefit set forth in subdivisions 1 and 2 of this subsection may be
96 converted when medically necessary at the option of the person or the parent, as defined in § 16.1-336, of
97 a child or adolescent receiving such treatment to a partial hospitalization benefit applying a formula which
98 shall be no less favorable than an exchange of 1.5 days of partial hospitalization coverage for each
99 inpatient day of coverage. An insurance policy or subscription contract described herein that provides
100 inpatient benefits in excess of 20 days per policy or contract year for adults or 25 days per policy or
101 contract year for a child or adolescent may provide for the conversion of such excess days on the terms
102 set forth in this subdivision.

103 4. The limits of the benefits set forth in this subsection shall not be more restrictive than for any
104 other illness, except that the benefits may be limited as set out in this subsection.

105 5. This subsection shall not apply to any excepted benefits policy as defined in § 38.2-3431, nor
106 to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the
107 Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental
108 plans.

109 D. Any grandfathered plan as defined in § 38.2-3438 in the small group market shall also either
110 continue to provide benefits in accordance with subsection B or continue to provide coverage for
111 outpatient mental health and substance abuse services as follows:

112 1. A minimum of 20 visits for outpatient treatment of an adult, child or adolescent shall be provided
113 in each policy or contract year.

114 2. The limits of the benefits set forth in this subsection shall be no more restrictive than the limits
115 of benefits applicable to physical illness; however, the coinsurance factor applicable to any outpatient visit
116 beyond the first five of such visits covered in any policy or contract year shall be at least 50 percent.

117 3. For the purpose of this section, medication management visits shall be covered in the same
118 manner as a medication management visit for the treatment of physical illness and shall not be counted as
119 an outpatient treatment visit in the calculation of the benefit set forth herein.

120 4. For the purpose of this subsection, if all covered expenses for a visit for outpatient mental health
121 or substance abuse treatment apply toward any deductible required by a policy or contract, such visit shall
122 not count toward the outpatient visit benefit maximum set forth in the policy or contract.

123 5. This subsection shall not apply to any excepted benefits policy as defined in § 38.2-3431, nor
124 to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the
125 Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental
126 plans.

127 E. The requirements of this section shall apply to all insurance policies and subscription contracts
128 delivered, issued for delivery, reissued, renewed, or extended, or at any time when any term of the policy
129 or contract is changed or any premium adjustment made.

130 F. The provisions of this section shall not apply in any instance in which the provisions of this
131 section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

132 G. The Bureau of Insurance, in consultation with health carriers providing coverage for mental
133 health and substance use disorder benefits pursuant to this section, shall develop reporting requirements
134 regarding denied claims, complaints, appeals, and network adequacy involving such coverage set forth in
135 this section. By November 1 of each year, the Bureau shall compile the information for the preceding year
136 into a report that ensures the confidentiality of individuals whose information has been reported and is
137 written in nontechnical, readily understandable language. The Bureau shall include in the report a
138 summary of all comparative analyses prepared by health carriers pursuant to 42 U.S.C. § 300gg-26(a)(8)
139 that the Bureau requested during the reporting period. This summary shall include the Bureau's
140 explanation of whether the analyses were accepted as compliant, rejected as noncompliant, or are in
141 process of review. For analyses that were noncompliant, the report shall include the corrective actions that
142 the Bureau required the health carrier to take to come into compliance. The Bureau shall make the report
143 available to the public by, among such other means as the Bureau finds appropriate, posting the reports
144 on the Bureau's website and submit the report to the House Committee on Commerce and Energy and the
145 Senate Committee on Commerce and Labor.

146 **§ 38.2-3438. Definitions.**

147 As used this article, unless the context requires a different meaning:

148 "Allowed amount" means the maximum portion of a billed charge a health carrier will pay,
149 including any applicable cost-sharing requirements, for a covered service or item rendered by a
150 participating provider or by a nonparticipating provider.

151 "Balance bill" means a bill sent to an enrollee by an out-of-network provider for health care
152 services provided to the enrollee after the provider's billed amount is not fully reimbursed by the carrier,
153 exclusive of applicable cost-sharing requirements.

154 "Behavioral health crisis service provider" means a provider licensed by the Department of
155 Behavioral Health and Developmental Services to provide mental health or substance use services as a
156 provider of mobile crisis response, residential crisis stabilization, or a crisis receiving center.

157 "Child" means a son, daughter, stepchild, adopted child, including a child placed for adoption,
158 foster child, or any other child eligible for coverage under the health benefit plan.

159 "Cost-sharing requirement" means an enrollee's deductible, copayment amount, or coinsurance
160 rate.

161 "Covered benefits" or "benefits" means those health care services to which an individual is entitled
162 under the terms of a health benefit plan.

163 "Covered person" means a policyholder, subscriber, enrollee, participant, or other individual
164 covered by a health benefit plan.

165 "Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of
166 the policy, contract, or plan covering the eligible employee.

167 "Emergency medical condition" means, regardless of the final diagnosis rendered to a covered
168 person, a medical condition manifesting itself by acute symptoms of sufficient severity, including severe
169 pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could
170 reasonably expect the absence of immediate medical attention to result in (i) serious jeopardy to the mental
171 or physical health of the individual, (ii) danger of serious impairment to bodily functions, (iii) serious
172 dysfunction of any bodily organ or part, or (iv) in the case of a pregnant woman, serious jeopardy to the
173 health of the fetus.

174 "Emergency services" means with respect to an emergency medical condition (i) (a) a medical
175 screening examination as required under § 1867 of the Social Security Act (42 U.S.C. § 1395dd) that is
176 within the capability of the emergency department of a hospital, including ancillary services routinely
177 available to the emergency department to evaluate such emergency medical condition, and ~~(ii) (b) such~~
178 further medical examination and treatment, to the extent they are within the capabilities of the staff and
179 facilities available at the hospital, as are required under § 1867 of the Social Security Act (42 U.S.C. §
180 1395dd (e)(3)) to stabilize the patient, and (ii) as it relates any mental health services or substance abuse
181 services, as those terms are defined in § 38.2-3412.1, rendered at a behavioral health crisis service provider
182 (a) a behavioral health assessment that is within the capability of a behavioral health crisis service
183 provider, including ancillary services routinely available to evaluate such emergency medical condition,
184 and (b) such further examination and treatment, to the extent that they are within the capabilities of the

185 staff and facilities available at the behavioral health crisis service provider, as are required so that the
186 patient's condition does not deteriorate.

187 "ERISA" means the Employee Retirement Income Security Act of 1974.

188 "Essential health benefits" include the following general categories and the items and services
189 covered within the categories in accordance with regulations issued pursuant to the PPACA as of January
190 1, 2019: (i) ambulatory patient services; (ii) emergency services; (iii) hospitalization; (iv) laboratory
191 services; (v) maternity and newborn care; (vi) mental health and substance abuse disorder services,
192 including behavioral health treatment; (vii) pediatric services, including oral and vision care; (viii)
193 prescription drugs; (ix) preventive and wellness services and chronic disease management; and (x)
194 rehabilitative and habilitative services and devices.

195 "Facility" means an institution providing health care related services or a health care setting,
196 including hospitals and other licensed inpatient centers; ambulatory surgical or treatment centers; skilled
197 nursing centers; residential treatment centers; diagnostic, laboratory, and imaging centers; and
198 rehabilitation and other therapeutic health settings.

199 "Genetic information" means, with respect to an individual, information about: (i) the individual's
200 genetic tests; (ii) the genetic tests of the individual's family members; (iii) the manifestation of a disease
201 or disorder in family members of the individual; or (iv) any request for, or receipt of, genetic services, or
202 participation in clinical research that includes genetic services, by the individual or any family member of
203 the individual. "Genetic information" does not include information about the sex or age of any individual.
204 As used in this definition, "family member" includes a first-degree, second-degree, third-degree, or fourth-
205 degree relative of a covered person.

206 "Genetic services" means (i) a genetic test; (ii) genetic counseling, including obtaining,
207 interpreting, or assessing genetic information; or (iii) genetic education.

208 "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if
209 the analysis detects genotypes, mutations, or chromosomal changes. "Genetic test" does not include an
210 analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological
211 condition.

212 "Grandfathered plan" means coverage provided by a health carrier to (i) a small employer on
213 March 23, 2010, or (ii) an individual that was enrolled on March 23, 2010, including any extension of
214 coverage to an individual who becomes a dependent of a grandfathered enrollee after March 23, 2010, for
215 as long as such plan maintains that status in accordance with federal law.

216 "Group health insurance coverage" means health insurance coverage offered in connection with a
217 group health benefit plan.

218 "Group health plan" means an employee welfare benefit plan as defined in § 3(1) of ERISA to the
219 extent that the plan provides medical care within the meaning of § 733(a) of ERISA to employees,
220 including both current and former employees, or their dependents as defined under the terms of the plan
221 directly or through insurance, reimbursement, or otherwise.

222 "Health benefit plan" means a policy, contract, certificate, or agreement offered by a health carrier
223 to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. "Health
224 benefit plan" includes short-term and catastrophic health insurance policies, and a policy that pays on a
225 cost-incurred basis, except as otherwise specifically exempted in this definition. "Health benefit plan"
226 does not include the "excepted benefits" as defined in § 38.2-3431.

227 "Health care professional" means a physician or other health care practitioner licensed, accredited,
228 or certified to perform specified health care services consistent with state law.

229 "Health care provider" or "provider" means a health care professional or facility.

230 "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a
231 health condition, illness, injury, or disease.

232 "Health carrier" means an entity subject to the insurance laws and regulations of the
233 Commonwealth and subject to the jurisdiction of the Commission that contracts or offers to contract to
234 provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an
235 insurer licensed to sell accident and sickness insurance, a health maintenance organization, a health
236 services plan, or any other entity providing a plan of health insurance, health benefits, or health care
237 services.

238 "Health maintenance organization" means a person licensed pursuant to Chapter 43 (§ 38.2-4300
239 et seq.).

240 "Health status-related factor" means any of the following factors: health status; medical condition,
241 including physical and mental illnesses; claims experience; receipt of health care services; medical history;
242 genetic information; evidence of insurability, including conditions arising out of acts of domestic violence;
243 disability; or any other health status-related factor as determined by federal regulation.

244 "Individual health insurance coverage" means health insurance coverage offered to individuals in
245 the individual market, which includes a health benefit plan provided to individuals through a trust
246 arrangement, association, or other discretionary group that is not an employer plan, but does not include
247 coverage defined as "excepted benefits" in § 38.2-3431 or short-term limited duration insurance. Student
248 health insurance coverage shall be considered a type of individual health insurance coverage.

249 "Individual market" means the market for health insurance coverage offered to individuals other
250 than in connection with a group health plan.

251 "In-network" or "participating" means a provider that has contracted with a carrier or a carrier's
252 contractor or subcontractor to provide health care services to enrollees and be reimbursed by the carrier at
253 a contracted rate as payment in full for the health care services, including applicable cost-sharing
254 requirements.

255 "Managed care plan" means a health benefit plan that either requires a covered person to use, or
256 creates incentives, including financial incentives, for a covered person to use health care providers
257 managed, owned, under contract with, or employed by the health carrier.

258 "Network" means the group of participating providers providing services to a managed care plan.

259 "Nonprofit data services organization" means the nonprofit organization with which the
260 Commissioner of Health negotiates and enters into contracts or agreements for the compilation, storage,
261 analysis, and evaluation of data submitted by data suppliers pursuant to § 32.1-276.4.

262 "Offer to pay" or "payment notification" means a claim that has been adjudicated and paid by a
263 carrier or determined by a carrier to be payable by an enrollee to an out-of-network provider for services
264 described in subsection A of § 38.2-3445.01.

265 "Open enrollment" means, with respect to individual health insurance coverage, the period of time
266 during which any individual has the opportunity to apply for coverage under a health benefit plan offered
267 by a health carrier and must be accepted for coverage under the plan without regard to a preexisting
268 condition exclusion.

269 "Out-of-network" or "nonparticipating" means a provider that has not contracted with a carrier or
270 a carrier's contractor or subcontractor to provide health care services to enrollees.

271 "Out-of-pocket maximum" or "maximum out-of-pocket" means the maximum amount an enrollee
272 is required to pay in the form of cost-sharing requirements for covered benefits in a plan year, after which
273 the carrier covers the entirety of the allowed amount of covered benefits under the contract of coverage.

274 "Participating health care professional" means a health care professional who, under contract with
275 the health carrier or with its contractor or subcontractor, has agreed to provide health care services to
276 covered persons with an expectation of receiving payments, other than coinsurance, copayments, or
277 deductibles, directly or indirectly from the health carrier.

278 "PPACA" means the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by
279 the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and as it may be further
280 amended.

281 "Preexisting condition exclusion" means a limitation or exclusion of benefits, including a denial
282 of coverage, based on the fact that the condition was present before the effective date of coverage, or if
283 the coverage is denied, the date of denial, whether or not any medical advice, diagnosis, care, or treatment
284 was recommended or received before the effective date of coverage. "Preexisting condition exclusion"
285 also includes a condition identified as a result of a pre-enrollment questionnaire or physical examination
286 given to an individual, or review of medical records relating to the pre-enrollment period.

287 "Premium" means all moneys paid by an employer, eligible employee, or covered person as a
288 condition of coverage from a health carrier, including fees and other contributions associated with the
289 health benefit plan.

290 "Preventive services" means (i) evidence-based items or services for which a rating of A or B is in
291 effect in the recommendations of the U.S. Preventive Services Task Force with respect to the individual

292 involved; (ii) immunizations for routine use in children, adolescents, and adults for which a
293 recommendation of the Advisory Committee on Immunization Practices of the Centers for Disease
294 Control and Prevention is in effect with respect to the individual involved; (iii) evidence-informed
295 preventive care and screenings provided for in comprehensive guidelines supported by the Health
296 Resources and Services Administration with respect to infants, children, and adolescents; and (iv)
297 evidence-informed preventive care and screenings recommended in comprehensive guidelines supported
298 by the Health Resources and Services Administration with respect to women. For purposes of this
299 definition, a recommendation of the Advisory Committee on Immunization Practices of the Centers for
300 Disease Control and Prevention is considered in effect after it has been adopted by the Director of the
301 Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if
302 it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention.

303 "Primary care health care professional" means a health care professional designated by a covered
304 person to supervise, coordinate, or provide initial care or continuing care to the covered person and who
305 may be required by the health carrier to initiate a referral for specialty care and maintain supervision of
306 health care services rendered to the covered person.

307 "Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that
308 has a retroactive effect. "Rescission" does not include:

309 1. A cancellation or discontinuance of coverage under a health benefit plan if the cancellation or
310 discontinuance of coverage has only a prospective effect, or the cancellation or discontinuance of coverage
311 is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or
312 contributions towards the cost of coverage; or

313 2. A cancellation or discontinuance of coverage when the health benefit plan covers active
314 employees and, if applicable, dependents and those covered under continuation coverage provisions, if
315 the employee pays no premiums for coverage after termination of employment and the cancellation or
316 discontinuance of coverage is effective retroactively back to the date of termination of employment due
317 to a delay in administrative recordkeeping.

318 "Stabilize" means with respect to an emergency medical condition, to provide such medical
319 treatment as may be necessary to assure, within reasonable medical probability, that no material
320 deterioration of the condition is likely to result from or occur during the transfer of the individual from a
321 facility, or, with respect to a pregnant woman, that the woman has delivered, including the placenta.

322 "Student health insurance coverage" means a type of individual health insurance coverage that is
323 provided pursuant to a written agreement between an institution of higher education, as defined by the
324 Higher Education Act of 1965, and a health carrier and provided to students enrolled in that institution of
325 higher education and their dependents, and that does not make health insurance coverage available other
326 than in connection with enrollment as a student, or as a dependent of a student, in the institution of higher
327 education, and does not condition eligibility for health insurance coverage on any health status-related
328 factor related to a student or a dependent of the student.

329 "Surgical or ancillary services" means professional services, including surgery, anesthesiology,
330 pathology, radiology, or hospitalist services and laboratory services.

331 "Wellness program" means a program offered by an employer that is designed to promote health
332 or prevent disease.

333 **§ 38.2-3445. Patient access to emergency services.**

334 A. Notwithstanding any provision of § 38.2-3407.11, 38.2-4312.3, or any other section of this title
335 to the contrary, if a health carrier providing individual or group health insurance coverage provides any
336 benefits with respect to services in an emergency department of a hospital, the health carrier shall provide
337 coverage for emergency services:

338 1. Without the need for any prior authorization determination, regardless of whether the emergency
339 services are provided on an in-network or out-of-network basis;

340 2. Without regard to the final diagnosis rendered to the covered person or whether the health care
341 provider furnishing the emergency services is a participating health care provider with respect to such
342 services;

343 3. If such services are provided out-of-network, without imposing any administrative requirement
344 or limitation on coverage that is more restrictive than the requirements or limitations that apply to such
345 services received from an in-network provider;

346 4. If such services are provided out-of-network, the health carrier shall pay the out-of-network
347 provider in accordance with § 38.2-3445.01 less any cost-sharing requirement. Any such cost-sharing
348 requirement shall not exceed the cost-sharing requirement that would apply if such services were provided
349 in-network as provided in § 38.2-3445.01; and

350 5. Without regard to any term or condition of such coverage other than the exclusion of or
351 coordination of benefits or an affiliation or waiting period.

352 B. Coverage for emergency services that are related to mental health services or substance abuse
353 services, as those terms are defined in § 38.2-3412.1, shall be provided in accordance with the federal
354 Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, even where those requirements
355 would not otherwise apply directly. Such emergency services may be rendered at a location other than the
356 emergency department of a hospital, such as a behavioral health crisis service provider, as required.

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