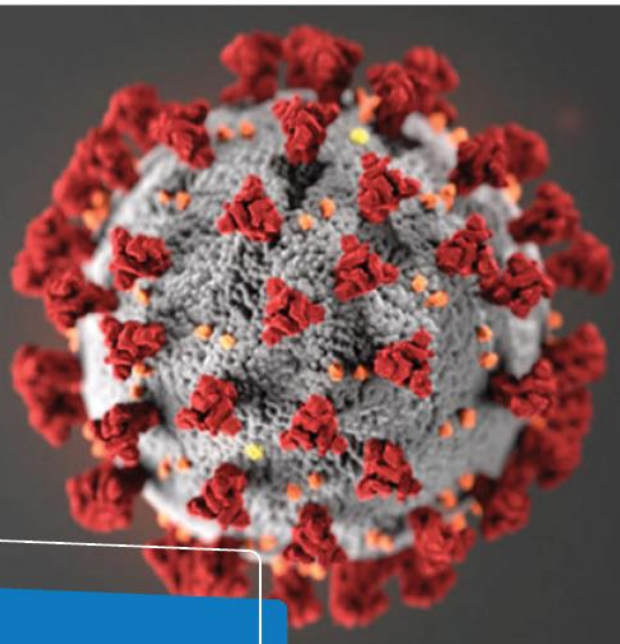
Empire BlueCross



Coronavirus (COVID-19)

FREQUENTLY ASKED QUESTIONS

What it is, how to prevent it, and what Empire benefits cover

June 10, 2020

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General Questions

What is coronavirus and what is COVID-19?
There are many types of human coronaviruses including some that commonly cause mild upper-respiratory tract illnesses. COVID-19 is a new disease caused by a new coronavirus that has not previously been seen in humans.

How do people become infected and how does it spread?
Current understanding about how the virus that causes COVID-19 spreads is largely based on what is known about similar coronaviruses. COVID-19 is a new disease and there is more to learn about how it spreads, the severity of illness it causes, and to what extent it may spread in the United States.

What are the symptoms of COVID-19?
People with COVID-19 have had a wide range of reported symptoms – ranging from mild symptoms to severe illness.

What if I am sick with COVID-19?
If you think you have been exposed to COVID-19 and develop a fever and symptoms of respiratory illness, such as cough or difficulty breathing, call your healthcare provider immediately. To help prevent the disease from spreading to people in your home and community, follow these CDC recommendations.

We also recommend the use of LiveHealth Online, as well as care received from other providers delivering telehealth, as a safe and helpful way to use Empire benefits to see a doctor to receive health guidance related to COVID-19 without leaving home using your smart phone, tablet or computer-enabled web cam.

How can I help protect myself?
The best way to prevent infection is to avoid being exposed to the virus that causes COVID-19.
Avoid close contact

- Avoid close contact with people who are sick

- Stay home as much as possible
- Put distance between yourself and other people.
- Keeping distance from others is especially important for people who are at higher risk of getting very sick.
- Practice good health habits. Everyday preventive actions help to prevent the spread of respiratory viruses.
    - Wash your hands often with soap and water for at least 20 seconds, especially after going to the bathroom; before eating; and after blowing your nose, coughing, or sneezing.
    - If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60 percent alcohol. Always wash hands with soap and water if hands are visibly dirty.
    - Avoid close contact with people who are sick.
    - Avoid touching your eyes, nose, and mouth.
    - Stay home when you are sick.
    - Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
    - Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe.

Cover your mouth and nose with a cloth face when around others

- Follow CDC's recommendations for using a face cloth cover.

Do I need to wear a face cloth cover?

It's best to follow the CDC's recommendations on how to protect yourself, including who should wear cloth covers and when. Also, it's important to know who should take extra precautions.

Where can a member get tested?

Members should call their provider to see how to get tested.

Do drugs exist to treat COVID-19?

- On May 1, 2020, the Food & Drug Administration issued an Emergency Use Authorization (EUA) for the antiviral drug remdesivir. While this EUA does not constitute an approval of this drug for the treatment of COVID-19, it does authorize the emergency use of the drug, as part of the current public health crisis, for the treatment of COVID-19 in patients meeting specific clinical criteria identified by the FDA.
- On March 28, 2020, the Food & Drug Administration issued an Emergency Use Authorization for the anti-malaria drugs chloroquine and hydroxychloroquine. While this EUA does not constitute an approval of this drug for the treatment of COVID-19, it does authorize the emergency use of the drug, as part of the current public health crisis, for the treatment of COVID-19 in patients meeting specific clinical criteria identified by the FDA.
- Neither of these drugs have received FDA approval for the treatment of COVID-19 and many are still being investigated.
- We are monitoring developments in this area closely and will evaluate coverage of any treatments once approved.

Are there any vaccines available to prevent COVID-19?

At the present time, no. Reports indicate there are several vaccines being evaluated but they are still in early stage development and have not been through clinical trials.

How is COVID-19 diagnosed?

COVID-19 may be suspected when a person has symptoms consistent with COVID-19, such as fever, cough or difficulty breathing, especially if there are risk factors for exposure to COVID-19, such as close contact with a confirmed COVID-19 patient or travel from affected geographic areas. A diagnosis is confirmed when other causes of respiratory disease, such as the flu, have been excluded, and a laboratory test has detected SARS-CoV-2, the virus that causes COVID-19. Other tests can help determine whether you have been exposed to SARS-CoV-2 (serology tests); these tests should be used to aid in the diagnosis of COVID-19 in conjunction with a medical review of symptoms and results of other laboratory tests.

How are patients tested for COVID-19?
Patients provide test samples in the doctor's office, emergency room or hospital. Some areas may also have drive-through COVID-19 testing sites. There, swabs from patients' nose, (and possibly mucus for those with a cough), will be collected and sent to a special lab to test for SARS-CoV-2, the virus that causes COVID-19. The specimens should be kept cold (2-8°C) and should generally be sent to a lab within three days.

A blood (serology) test can also help determine whether you have been exposed to SARS-CoV-2. These tests should be used to aid in the diagnosis of COVID-19 in conjunction with a medical review of symptoms and results of other laboratory tests.

When testing for COVID-19, should patients also need to test for other respiratory viruses?
Clinicians should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. While the CDC notes that clinicians are encouraged to test for other causes of respiratory illness, including infections such as influenza, in most cases, only a few other virus types require consideration (for example, influenza A and B with or without Respiratory Syncytial Virus). In most cases, it is unnecessary to test for more than five pathogen types in the specific patient being tested.

Coverage Questions

Is Empire waiving member cost share for diagnostic tests, visits and treatments related to COVID-19?
Empire is committed to help our members gain timely access to care and services. Our actions should help reduce barriers to seeing a doctor, getting tested and receiving treatment.

Empire is waiving:

- cost-sharing for the treatment of COVID-19 by in-network providers from April 1 through Dec. 31, 2020 for members of its fully-insured employer, Individual, Medicare Advantage and Medicaid plans. This includes FDA-

approved medications for the treatment of COVID-19 when they become available. We encourage our self-funded customers to participate and these plans will have an opportunity to opt in.

- cost-sharing for COVID-19 diagnostic tests, including serology or antibody tests, for members of our employer-sponsored, Individual, Medicare and Medicaid plans. This is effective throughout the duration of the public emergency.
- cost-sharing for COVID-19 screening related tests (e.g., influenza tests, blood tests, etc.) performed during a provider visit that results in an order for, or administration of, diagnostic testing for COVID-19 will also be covered with no cost sharing for members. This is effective throughout the duration of the public emergency.
- cost-sharing for visits to get the COVID-19 diagnostic test, regardless of whether the test is administered, beginning March 18 for members of our employer-sponsored, individual, Medicare and Medicaid plans. This is effective throughout the duration of the public emergency.
- cost-sharing for telehealth visits from in-network providers from March 17 through Sept. 30, 2020, including visits for behavioral health, for our fully-insured employer, individual, and Medicare Advantage plans, and where permissible, Medicaid plans. We encourage our self-funded customers to participate, although these plans will have an opportunity to opt in.
- cost-sharing for FDA-approved vaccines when they become available.

The cost-sharing waiver includes copays, coinsurance and deductibles. For additional services, members will pay any cost sharing their plan requires, unless otherwise determined by state law or regulation. Members can call the number on the back of their identification card to confirm coverage. Providers should continue to verify eligibility and benefits for all members prior to rendering services.

For what kind of COVID-19 treatments will member cost shares be waived?
For Empire's fully-insured employer, Individual, Medicare Advantage and Medicaid members, these treatments include services such as in-patient and out-patient services, respiratory services, durable medical equipment, skilled care needs, and FDA-approved drugs when they become available. We encourage our

self-funded customers to participate, and these plans will have an opportunity to opt in.

Does the cost-share waiver for treatment apply to prescription drugs?
Empire's waiver of member cost share associated with COVID-19 treatment would apply to FDA-approved medications or vaccines should they become available. At the present time, there are no medications that have FDA approval for use in the treatment of COVID-19.

Because there is insufficient data to fully support the safety and efficacy of using any existing drugs in the treatment of COVID-19, using them in this manner is considered outside of FDA approval, or "off label," and members would be responsible for any cost share.

Do drugs exist to treat COVID-19?

- On May 1, 2020, the Food & Drug Administration issued an Emergency Use Authorization (EUA) for the antiviral drug remdesivir. While this EUA does not constitute an approval of this drug for the treatment of COVID-19, it does authorize the emergency use of the drug, as part of the current public health crisis, for the treatment of COVID-19 in patients meeting specific clinical criteria identified by the FDA.
- On March 28, 2020, the Food & Drug Administration issued an Emergency Use Authorization for the anti-malaria drugs chloroquine and hydroxychloroquine. While this EUA does not constitute an approval of this drug for the treatment of COVID-19, it does authorize the emergency use of the drug, as part of the current public health crisis, for the treatment of COVID-19 in patients meeting specific clinical criteria identified by the FDA.
- Neither of these drugs have received FDA approval for the treatment of COVID-19 and many are still being investigated.
- We are monitoring developments in this area closely and will evaluate coverage of any treatments once approved.

The FDA has issued an Emergency Use Authorization, or EUA for remdesivir. What does this mean?

Based on a review of topline data from two clinical trials investigating the use of remdesivir for the treatment of COVID-19, on May 1, 2020, the Food & Drug Administration issued an EUA authorizing the emergency use of remdesivir for the hospital-based treatment of COVID-19 in adults and children with a suspected or confirmed case of COVID-19 and severe disease that meets specific clinical criteria.

- Remdesivir is an investigational anti-viral drug that is administered intravenously and is not currently indicated for any condition.
- The EUA does not constitute an approval of the drug, it's use is authorized only on a temporary basis, and distribution of the drug will be coordinated through the US government.
- At the present time, Gilead has stated that remdesivir will be provided at no cost through this EUA and, as a result, insurance will not be billed for its use.

Is Empire covering COVID-19 treatment for in-network and out-of-network providers?
From April 1 through Dec. 31, Empire will waive member cost shares for treatment from in-network providers, for our fully-insured employer plans, individual plans, Individual Medicare Advantage plans, Group Retiree Solutions plans and Medicaid plans, where permissible. For out-of-network providers, Empire is waiving cost shares from April 1 through May 31.

If a member is re-infected with COVID-19, does treatment fall under the covered benefit and are cost shares waived?
At this time, scientists are not sure if people can become re-infected with COVID-19. However, if a person does become re-infected, benefit coverage and cost share waivers for treatment would apply similar to how it does for any COVID-19 infection. Currently, cost shares have been waived for the treatment of COVID-19 from April 1 through Dec. 31, 2020. Treatment cost share waivers may vary for members who have self-insured plans, which have the ability to opt-in to member cost share waivers during April 1 through May 31, 2020 and April 1 through December 31, 2020. Out-of-network costs may also vary.

Under what conditions is diagnostic testing covered and cost shares waived?
Tests samples may be obtained in many settings including a doctor's office, urgent care, ER or even drive-thru testing. Laboratory diagnostic tests for COVID-19 at both in-network and out-of-network laboratories will be covered with no cost sharing for members.

While a test sample cannot be obtained through a telehealth visit at this time, a telehealth provider can help members get to a provider who can do so.

Are HMO members required to obtain an authorization/lab referral from their PCP to obtain a COVID-19 related lab test?
No. As stated in federal law, this coverage must be provided without cost sharing, when medically appropriate for the individual, as determined by the individual's attending healthcare provider in accordance with accepted standards of current

medical practice. This coverage must also be provided without imposing prior authorization or other medical management requirements.

How are diagnostic tests for COVID-19 reimbursed for contracted and non-contracted providers?

The federal mandate applies to both fully-insured and self-insured plans and requires payment direct to the non- contracted providers at the published cash price or a negotiated rate that is less than the cash price. For contracted providers, plans must cover testing at the provider's contracted rate. This applies to both fully-insured and self-insured plans.

Should serologic tests be used when trying to determine who should be allowed back in the workplace?

CDC guidelines indicate that the tests should not be used to determine whether people with antibodies can return to work.

Will Empire cover the cost of antibody/serology testing for COVID-19?

Yes, in accordance with the Federal Mandate, Empire will waive cost sharing for diagnostic testing, including antibody testing, for COVID-19. This coverage includes tests administered in hospital or other medical facilities, freestanding laboratories or medical offices, pharmacies and drive-up testing sites.

Empire supports the need for accessible and timely diagnostic testing and contact tracing to help manage the spread of COVID-19. Diagnostic testing – achieved through viral tests to detect current infection – is conducted when an individual has symptoms of COVID-19 infection or has known exposure to an individual with confirmed COVID-19. Diagnostic testing can also be conducted on individuals prioritized by departments of health for public health surveillance of COVID-19. Diagnostic testing is generally conducted using molecular technology which detects the virus's genetic material, but can also be conducted using antigen tests, which detect protein fragments of the virus. Diagnostic testing plays an important role in efforts to break the chain of transmission by identifying actively infected individuals. We encourage employers to follow CDC guidelines for the use of testing to confirm a current COVID-19 infection.

Antibody testing, also known as serology testing, identifies COVID-19 antibodies, which indicate whether an individual has had a past COVID-19 infection. Depending on when someone was infected and the timing of the test, the test may or may not also find antibodies in someone with a current COVID-19 infection. It is currently unknown whether the presence of antibodies indicates that someone is immune to COVID-19 infection or is unlikely to transmit the virus that causes COVID-19 — this is an active area of research. While a positive test for antibodies can imply previous COVID-19 infection, the reliability of the test result is limited except in populations for whom a previous infection is likely, such as health care workers, individuals who have had a documented COVID-19 infection confirmed with viral testing, or those with suspected COVID-19 infection based on a history of symptoms that resulted from a likely exposure.

Empire is aligned with the CDC's strategy to use antibody testing as a means of understanding how much of the U.S. population has been previously infected, how infection rates vary by region, and how rates may be changing over time. However, antibody testing is of limited value in helping to inform individual decision-making, including return-to-the-workplace strategies. Several groups, including the American Medical Association, have advised limited use of antibody testing. The AMA issued guidance noting that these tests should be limited to use in epidemiological/population-level studies and/or by physicians and laboratorians trained in the interpretation of serological tests and with a strong understanding of the limitations of the results. The AMA does not recommend individuals pursue antibody testing to make personal decisions on physical distancing or to attempt to determine immunity to COVID-19.

Given current uncertainty regarding what a positive antibody test results means, antibody tests should not be used to inform return-to-the-workplace strategies. Return-to-the-workplace strategies should focus on reducing the risk of transmission through mitigating strategies such as use of enhanced hygiene and cleaning protocols, implementing physical distance in the workplace, staggered shifts, cloth facial covers, as well as closely monitoring the health of employees to rapidly exclude sick individuals from the workplace.

Empire supports the need for accurate tests. It is important to realize that in this time of crisis, not all of the FDA Emergency Use Authorized tests for COVID-19 have been carefully evaluated or shown to be accurate in an appropriately

designed clinical study. Recently, more labs have started to offer direct-to-consumer testing that can be purchased without a care provider ordering the test, such as QuestDirect and others. If tests are purchased by a member directly from a lab and without a provider ordering and accurately billing for the test, these costs may be the consumer's responsibility as articulated by those labs direct-to-consumer programs.

Does Empire cover COVID-19 home or self-administered diagnostic tests? Does it waive cost shares for these tests?

We will cover home and self-administered COVID-19 diagnostic tests when the test meets the following coverage requirements:

- the test or laboratory providing the test has authorization from the appropriate government regulatory body, such as the Food and Drug Administration or a state laboratory authority;
- the test is medically necessary and;
- the test is ordered by a licensed practitioner.

Empire will waive cost shares for home or self-administered COVID-19 tests when the test meets the coverage requirements.

Is Empire providing Medicare members with post-discharge support?

Empire will also provide post-discharge care to support Medicare members with complex care needs who may need additional assistance as they transition back to home following hospitalization. Empire's care managers can help provide coordination of medications and home health needs, scheduling follow up appointments and transportation.

Are cost shares waived for all providers who offer telehealth?

Cost sharing will be waived for members using <<CompanyName>'s telehealth service, LiveHealth Online, as well as care received from other in-network providers delivering virtual care from March 17 through Sept. 13, 2020 or any longer period required by state law. Co-pays for physical and behavioral telehealth visits for health conditions will be waived. For out-of-network

providers, <<CompanyName> is waiving cost shares through March 17 through June 14, 2020.

How is Empire covering telemedicine?

Telemedicine (video + audio via app): Starting March 17, 2020, Empire began waiving member cost sharing for telemedicine (video + audio) visits including covered visits for mental health and substance use disorders, for our fully insured employer plans, Individual plans, Medicare plans and Medicaid plans, where permissible. This applies to use of our LiveHealth Online platform, as well as for care received from other providers delivering virtual care through internet video and audio services. Self-insured plan sponsors may opt out of this program.

This will remain in place for 90 days or as long as the emergency New York rule is in effect. Members can call the number on the back of their identification card to confirm coverage. Providers should continue to verify eligibility and benefits for all members prior to rendering services.

Telehealth visits (phone with video capability): Starting March 19, 2020, Empire began waiving member cost sharing for telehealth visits with in-network and out-of-network providers acting within the scope of their license. This includes covered visits for behavioral health and substance use disorders and medical services, where medically appropriate if other requirements for a covered health service are met. This applies to fully-insured employer plans, individual plans, Medicare and Medicaid plans, where permissible. Self-insured plan sponsors may opt out of this program. Phone/video delivery must be HIPAA compliant. This will remain in place for 90 days or as long as the emergency NY rule is in effect.
Note: Telehealth does not include the use of facsimile, telephone-only, or email.

Telephonic-only care

For 90 days effective March 19, 2020, Empire will cover telephonic-only visits with in-network providers. Out-of-network coverage will be provided where required.

- This includes visits for behavioral health, for our fully insured employer plans, individual plans, Medicare plans and Medicaid plans, where permissible.

- Cost shares will be waived for in-network providers only. Self-insured plan sponsors may opt out of this program.
- Exceptions include chiropractic services, physical, occupational, and speech therapies. These services are not appropriate for telephone-only consultations. Self-insured plan sponsors may opt out of this program. Phone delivery must be HIPAA compliant.

If I am incorrectly charged for LiveHealth Online visits, will I be reimbursed?
Members who may have been incorrectly charged for their telehealth visit via LiveHealth Online will receive a refund back to the credit card used at the time of visit.

Do the waivers apply to out-of-network providers for testing and office visits related to testing?
If an in-network provider is not available, Empire will work with members to find an out-of-network provider and then the waivers would apply.

Will cost shares associated with testing and related services be waived for members enrolled in high-deductible health plans with HSAs?
Cost shares associated with testing and related services may be waived for members enrolled in high-deductible health plans, or HDHP with HSAs. Based on IRS guidance, such cost share waivers will not jeopardize the status of the plan as an HDHP. In addition, benefits can be provided for treatment before having to meet the HDHP deductible.

If a member is treated for COVID-19 outside the United States, will coverage apply and will out-of-pocket waivers apply?
Yes, a member's regular coverage would apply for testing and treatment of COVID-19, just like it does in the United States. Member cost shares for the focused test used to diagnose COVID-19 and the visit related to the test will be waived for members—specifically, individual, Medicare and Medicaid members, as well as members in self-insured and other fully-insured plans.

If a member needs to be quarantined, does Empire cover that?

Empire health plans will cover reasonable health care costs for members related to COVID-19. Members will pay any cost shares their plan requires, unless otherwise determined by state law or regulation.

How can you ensure that your contracted providers can still provide services during the pandemic?
Empire is committed to working with and supporting its contracted providers. Our benefits already state that if members do not have appropriate access to network doctors that we will authorize coverage for out-of-network doctors as medically necessary.

In addition, Empire's telehealth provider, LiveHealth Online, is another safe and effective way for members to see a doctor to receive health guidance related to COVID-19 from their home via mobile device or a computer with a webcam.

Are you aware of any limitations in coverage for treatment of an illness/virus/disease that is part of an epidemic?
Our standard contracts do not have exclusions or limitations on coverage for services for the treatment of illnesses that result from an epidemic.

A member received a notice that a claim will be denied if the member does not submit additional information within a certain timeframe. Is this correct?
The timeframe is correct, but Anthem will disregard days that occur during the National Emergency or Outbreak Period. Anthem will count days against the timeframe provided under the notice once the National Emergency or Outbreak Period ends. If the notice includes a due date, this due date can be used to determine how much additional time is available once the National Emergency or Outbreak Period ends.

What is the outbreak period?
Please note, the "Outbreak Period" is a definition that provides additional relief for a particular location beyond that which is generally applicable under the declaration of the National Emergency.
The "Outbreak Period" is defined as the period beginning March 1, 2020 and ending 60 days after the date on which the federal government declares the

COVID-19 national emergency has ended with respect to a particular location (which has yet to be determined) and may be announced by the Department of Labor and Treasury in a future notice. The Outbreak Period may not be longer than one year.
As an Outbreak Period has not been announced for any particular location. Anthem recommends that employers monitor updates by visiting the Department of Labor's website.

How is Anthem addressing Federal Guidance that pushes back due dates for enrollment, claims, grievances and appeals, and independent external review?
Under the guidance, ERISA group health and disability plans must push back certain due dates effective March 1 until 60 days after the end of the declaration of the National Emergency or "Outbreak Period," whichever is later.
The following due dates are suspended:

- The 30-day period (or 60-day period, if applicable) to request special enrollment
- The 60-day election period for COBRA continuation coverage
- The date for making COBRA premium payments
- The date for individuals to notify the plan of a qualifying event or determination of disability
- The date within which individuals may file a benefit claim under the plan's claims procedure
- The date within which claimants may file an appeal of an adverse benefit determination under the plan's claims procedure
- The date within which claimants may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination
- The date within which a claimant may file information to perfect a request for external review upon a finding that the request was not complete.

Anthem will enroll participants and suspend timeframes for claims and appeals in a manner consistent with the guidance for group health and disability plans effective March 1, 2020. Anthem will forward independent external reviews requests consistent with plan timeframes.

A member received a notice that COBRA coverage will be cancelled if payment is not made within a certain timeframe. Is this correct?
The timeframe is correct, but Anthem will disregard days that occur during the National Emergency or Outbreak Period. Anthem will count days against the timeframe provided under the notice once the National Emergency or Outbreak Period ends. If the notice includes a due date, this due date can be used to determine how much additional time is available once the National Emergency or Outbreak Period ends.

How much additional time will members have to submit eligibility, COBRA payment, or claims information?
It depends. Timeframes are suspended until 60 days after the end of the National Emergency or Outbreak Period. After this 60-day period, Anthem will start counting days against timeframes. Because each situation may be different, Anthem recommends submitting information as soon as possible. Please see specific examples under **Federal Guidance** for more information.

If claims are rejected because a member's eligibility or payment information is not current, can claims be reprocessed if updated eligibility or payment information is provided?
Yes. Anthem can reprocess claims if updated payment or eligibility information is provided. If claims need to be reprocessed based upon updated eligibility and/or payment information, members should contact Anthem using the number on their ID card.

Will Anthem provide notice that the National Emergency or Outbreak Period has ended?
Anthem will cascade notice to group health disability plans that the National Emergency or Outbreak Period has ended. However, we recommend monitoring the Department of Labor's website for additional updates.

Telehealth, Telemedicine, Sydney Care and 24/7 NurseLine

Telehealth and Telemedicine

Is Empire encouraging broader use of telehealth and telemedicine?
We are recommending members use telehealth or telemedicine when they can as it reduces the burden on the healthcare system, prevents members from spreading a virus and can help protect them from getting a virus while waiting with others at a physical facility.

We also encouraging members access our Sydney Care app at no cost. The app includes a Coronavirus Assessment, available soon, that can help members quickly and safely evaluate their symptoms and assess their risk and then communicate with a doctor to address additional questions. Members can download the Sydney Care app on Android or iOs.

Why is telehealth and telemedicine a good option to receive individual health guidance related to COVID-19?
We are recommending members use telemedicine and telehealth when they can as it prevents them from spreading a virus to others in a waiting room or clinic and can help protect them from getting a virus while waiting with others at a physical facility.

LiveHealth Online is a safe and helpful way use Empire benefits to see a doctor to receive health guidance related to COVID-19 without leaving home, using your smart phone, tablet or computer-enabled web cam.

While COVID-19 can't be confirmed through virtual or remote care, care teams can screen members, assign risk, answer questions and recommend the next steps a member should take. Patients with COVID-19 who are at low risk are treated in the home unless they are sick enough to require in-person care.

Is <<CompanyName> waiving member cost shares associated with LiveHealth Online and other telehealth visits for COVID-19?

From March 17 through Sept. 13, 2020 or any longer period required by NY state law, <<CompanyName> will waive member cost share for telehealth visits, including visits for behavioral health, for members of our employer-sponsored, individual, and Medicare Advantage plans, and where permissible, Medicaid plans.

Cost sharing will be waived for members using <<CompanyName>'s telehealth service, LiveHealth Online, as well as care received from other providers delivering virtual care. Co-pays for physical and behavioral telehealth visits for health conditions will be waived. Self-insured plan sponsors will have the choice to participate.

If I am incorrectly charged for LiveHealth Online visits, will I be reimbursed?
Members who may have been incorrectly charged for their telehealth visit via LiveHealth Online will receive a refund back to the credit card used at the time of visit.

Are there tax implications for members with HSA and certain high-deductible plans who get their cost sharing waived for a telemedicine or telehealth visit?
Cost shares may be waived for telehealth services for members enrolled in HSA/high deductible health plans without tax implications to members.

Can HSAs and certain high deductible plans offer telehealth with no cost sharing?
Upon passage, in 2020 and 2021 the Coronavirus Aid, Recovery and Economic Stability Act would allow high deductible health plans coupled with health savings accounts to provide telehealth and other remote care services without a deductible.

Are member cost shares waived for Empire members who have a telemedicine provider other than LiveHealth Online?

Yes. Cost sharing will be waived for 90 days, effective March 17, 2020, for members using Empire's telehealth service, LiveHealth Online, as well as care received from other providers delivering telehealth. This applies to members who have Medicaid, Medicare, individual and employer-sponsored plans. Self-insured plan sponsors will have the choice to participate.

24/7 NurseLine

Can members use 24/7 NurseLine if they suspect symptoms of COVID-19?

Yes. 24/7 NurseLine has trained nurses to ask additional probing questions to members with respiratory symptoms and coached nurses to use updated HealthWise Connect COVID-19 information and the CDC web site.

- NurseLine is available to most Empire members who have Medicaid, Medicare, individual and employer-based plans.
- The number is typically on the back for the member ID card. Most Medicaid members access the service through member services.

How does 24/7 NurseLine work?

NurseLine assesses a member's symptoms, and triages the member to the most appropriate level of care, based on those symptoms.

- NurseLine nurses use HealthWise Connect algorithms for assessment and triage.
- If member has respiratory symptoms, such as fever, cough, and shortness of breath, the NurseLine associate will ask additional probing questions, including the date that the member's symptoms started, and whether the member has been exposed to someone with COVID-19.
- NurseLine may refer members to their provider, urgent care, ER or LiveHealth Online based on the severity of symptoms. Doctors in these other settings also have the ability to prescribe medications for viruses and other ailments—unlike COVID-19—that have treatments.
- If the member's history suggests the potential for COVID-19 infection or exposure, NurseLine nurses will offer an assessment and recommend that they contact their provider for additional recommendations.

An additional option is the use of telehealth. We are recommending members use telehealth when they can as it prevents them from spreading a virus to others in a waiting room or clinic and can help protect them from getting or spreading a virus while waiting with others at a physical facility. While COVID-19 can't be confirmed through virtual or remote care, care teams can screen members, assign risk, answer questions and recommend the next steps a member should take.

Sydney Care

What is Sydney Care?

Sydney Care is a digital care access platform offering a suite of health services via a downloadable app.

- **Symptom Checker**: Personalized, AI-driven chat functionality that can understand the symptoms users indicate and provide them with knowledge about how others were diagnosed and treated. Sydney Care offers two options (below) to follow-up on the information provided during the Symptom Checker dialogue.
- **Virtual Text Visit**: Enables consumers to connect directly with a board-certified physician via text chat, should consumers desire to have a chat-based clinical evaluation. When appropriate, these physicians can prescribe medication, order lab work and/or suggest the type of specialist they may want to consult.
- **Virtual Video Visit**: Similar to the Virtual Text Visit, the Virtual Video Visit option – through LiveHealth Online – is a secure, two-way video chat with a board-certified doctor. These physicians can also prescribe medication or make specialist recommendations.

How does the Sydney Care mobile app work in regards to coronavirus?

Empire is working to accelerate the availability of a *Coronavirus Assessment* on the Sydney Care mobile app, which members can download at no cost.

- The *Coronavirus Assessment* is designed based on guidelines from the Centers for Disease Control and Prevention and National Institutes of Health to help individuals quickly and safely evaluate their symptoms and assess their risk of having COVID-19.

- Inputs provided by individual users include symptoms, recent travel and potential contact with anyone with the disease.
- Based on the results, Empire members will be able to connect directly to a board certified-doctor via the Sydney Care app who can recommend care options.

How do members find it?
Sydney Care is available for Empire members to download now on Android or iOS. This app should accompany their Sydney Health or Engage benefits app. *Coronavirus Assessment* functionality is in development and expected to be available within the next week.

Pharmacy Questions

Do drugs exist to treat COVID-19?

- On May 1, 2020, the Food & Drug Administration issued an Emergency Use Authorization (EUA) for the antiviral drug remdesivir. While this EUA does not constitute an approval of this drug for the treatment of COVID-19, it does authorize the emergency use of the drug, as part of the current public health crisis, for the treatment of COVID-19 in patients meeting specific clinical criteria identified by the FDA.
- On March 28, 2020, the Food & Drug Administration issued an Emergency Use Authorization for the anti-malaria drugs chloroquine and hydroxychloroquine. While this EUA does not constitute an approval of this drug for the treatment of COVID-19, it does authorize the emergency use of the drug, as part of the current public health crisis, for the treatment of COVID-19 in patients meeting specific clinical criteria identified by the FDA.
- Neither of these drugs have received FDA approval for the treatment of COVID-19 and many are still being investigated.
- We are monitoring developments in this area closely and will evaluate coverage of any treatments once approved.

What are we doing to address potential drug shortages related to the current COVID-19 outbreak?

- IngenioRx is carefully monitoring the global drug supply for any disruptions related to COVID-19 and, at the present time we have not identified any disruptions that would affect members' abilities to fill their prescriptions through either our mail order facility or our retail networks.
- Additionally, the Food and Drug Administration is closely monitoring medications for any potential supply chain disruptions.
- Given the evolving nature of the outbreak, we will continue to monitor the situation and will work to address issues as they arise.

The FDA has issued an Emergency Use Authorization, or EUA for remdesivir. What does this mean?

Based on a review of topline data from two clinical trials investigating the use of remdesivir for the treatment of COVID-19, on May 1, 2020, the Food & Drug Administration issued an EUA authorizing the emergency use of remdesivir for the hospital-based treatment of COVID-19 in adults and children with a suspected or confirmed case of COVID-19 and severe disease that meets specific clinical criteria.

- Remdesivir is an investigational anti-viral drug that is administered intravenously and is not currently indicated for any condition.
- The EUA does not constitute an approval of the drug, it's use is authorized only on a temporary basis, and distribution of the drug will be coordinated through the US government.
- At the present time, Gilead has stated that remdesivir will be provided at no cost through this EUA and, as a result, insurance will not be billed for its use.

How are you handling off-label use of approved FDA drugs? What steps are you taking that sufficient supply remains for on-label use?

- We continue to apply our utilization management criteria, consistent with existing clinical guidance for all prescription medications. This includes the application of prior authorizations and quantity limits.
- In addition, in an abundance of caution, we have added, and will continue to enforce, quantity limits for the prescription medicines chloroquine and

hydroxychloroquine to ensure that those who need it for non-COVID 19 treatments can still continue their evidence-based drug therapy as well as to minimize off-label use.

- In addition, our existing clinical criterial places quantity limits on drugs like azithromycin, protease inhibitors, and albuterol inhalers which have been used by some in an off-label setting for COVID-19. We are closely monitoring utilization and regularly evaluate the need to place additional controls on these drugs given the evolving situation.

Are there shortages of critical medications like insulin and asthma medications?

- We are in regular contact with drug manufacturers and our retail pharmacy partners regarding availability of prescription drugs and we have been told that there are no concerns about the supply chain at this time.
- Several of the major manufacturers have assured us that there are no issues with the supply of insulin.
- There has been an increase in the utilization of albuterol inhalers and, as a result, retail pharmacies are monitoring supplies closely and restocking more frequently.
- In addition, several manufacturers and wholesalers are applying an "allocation" protocol to select drugs to prevent any individual pharmacy from hoarding drug supply. This does not mean that there is a shortage, it simply means that steps are being taken to prevent a pharmacy from ordering an excessive amount of a given drug and creating unnecessary distribution issues.

How are you managing the increased utilization of drugs like chloroquine and hydroxychloroquine?

- We will continue to cover these drugs according to our existing clinical policies however, where allowed by local regulations, we have implemented quantity limits on chloroquine and hydroxychloroquine for our Commercial and Medicaid businesses. This will limit prescriptions to a 10-day supply for any individual who does not have a documented history of chronic use of this drug.

- Should the FDA approve the use of any of these drugs for the treatment or prevention of COVID-19 we will immediately reevaluate our coverage policies.
- Dispensing pharmacies will be required to follow any state regulations regarding the dispensing of chloroquine and hydroxychloroquine. State and federal mandates around this issue supersede IngenioRx policies.

What would members do if there is a shortage of a medication that they are currently taking?

In the event that we identify a shortage with a particular drug, we will review its current formulary strategy to identify temporary changes that would allow a member to access an appropriate therapeutic alternative at cost share that is similar to the drug that is experiencing the shortage.

What steps should members take to avoid being impacted by a potential drug shortage?

- It is critically important that members who are on maintenance medications take their prescriptions and continue to refill their medications as prescribed by their doctor.
- IngenioRx has several programs designed to help members remain adherent to their prescription drug therapy but, if a member is concerned about running out of their medication, there are things they can do to be prepared.
    - For members who participate in a plan that offers a 90-day benefit, this is a great time to think about changing any prescription medicines you take on a regular basis from a 30-day supply to a 90-day supply. If you don't have a prescription for a 90-day supply, talk to your doctor to see if a 90-day supply would work for you.
    - In addition, we have announced that we are relaxing our early refill criteria for certain types of medications. Where allowed by local regulations, we will allow you to refill your prescription early through an emergency refill at your local pharmacy. Your pharmacist will be able to submit the request for an emergency refill on your behalf.

- Members can call the pharmacy services number on the back of their health plan ID card to learn more about these programs.

Empire announced that it is waiving member cost shares related to COVID-19 treatment. Does this apply to prescription drugs?

- Empire's waiver of member cost share associated with COVID-19 treatment would apply to FDA-approved medications or vaccines that directly treat the COVID-19 virus should they become available.
- At the present time, there are no medications that have FDA approval for use in the direct treatment of COVID-19.
- Because there is insufficient data to fully support the safety and efficacy of using any existing drugs for the treatment of COVID-19, using them in this manner is considered outside of FDA approval (i.e. off label") and members would be responsible for any cost share.
- Members will continue to be responsible for their usual portion of the drug cost, as defined by their plan, for any prescriptions used as supportive treatment and/or to treat secondary conditions caused by the virus.

Should members be concerned about long lines and delays in filling prescriptions at retail pharmacies?

- We are in regular contact with each of the major pharmacy chains. While they have reported that they have seen increased foot traffic, they have all stated that they are managing the increased volumes.
- Additionally, each of our retail partners have reassured us that they are monitoring the drug supply and taking steps to ensure that they have adequate supply of critical prescription drugs.
- If members are concerned, and their plan has a 90-day benefit, this is a great time to think about changing any prescription medicines you take on a regular basis from a 30-day supply to a 90-day supply. If you don't have a prescription for a 90-day supply, talk to your doctor to see if a 90-day supply would work for you.

What delivery options do members have through local pharmacies?

- In terms of delivery options from local pharmacies, many of the retail pharmacy chains, as well as local independent pharmacies, offer delivery service.
- Since the services offered at individual retail locations can change often, we do not have any way to monitor whether or not a particular pharmacy offers delivery and what, if any, cost there might be for that service.
- We would encourage any member that is interested in a local delivery service to contact their current pharmacy to determine whether or not they currently offer delivery. They can search for in-network pharmacies using the find a pharmacy tool on your health plan website/app and find contact information for the individual pharmacy there.

Is Walgreens reducing its store hours?

- Walgreens has advised us that they will be limiting the hours of operations for their retail stores to 9am to 9pm local time. While closed, Walgreens will be using the time to spend time on deep cleaning, sanitizing and stocking shelves.
- It is important to note that this applies only to the retail portion of their stores and Walgreens has advised us that pharmacy operating hours are, generally speaking, not impacted.
- At Walgreens locations with a 24-hour pharmacy, the pharmacy drive-thru will remain open 24 hours to assist customers and patients with their prescriptions.
- We have not heard of any changes from other retail pharmacy chains but are monitoring the situation closely. Members should visit their pharmacy's website to stay up to date on their hours as well as any details on delivery services they may offer.

Empire relaxed the early refill limits for maintenance medications. What does this mean?

As a result of the president's declaration of a national health emergency, we are implementing our standard operating procedures tied to declarations of emergency, including relaxing early refill limits for medications.

- This means that members who wish to refill a prescription earlier than normal should be able to do so.
- Pharmacists are able to submit an override of early refill limits for members who wish to refill a prescription earlier than is indicated based on the day supply they have previously received.
- Also, since the beginning of concerns about COVID-19, Empire has advised members to consider filling a 90-day supply of maintenance medications, where appropriate, to ensure that they have a sufficient supply of medications that are taken regularly on hand.
- Consistent with CDC recommendations, and to avoid unjustified pressure on the pharmacy supply chain, we have advised members against "stockpiling" medication unnecessarily and will continue to support policies that allow members to obtain their medications in a safe and effective manner. As a result, we are currently limiting members to a single early refill over the next 180 days, where allowed by state regulations.

If a member recently filled their prescription, will IngenioRx allow an early refill of the prescription?

- Yes. For members who are worried about having enough of their prescribed medication on hand, we have relaxed our early refill criteria. This means that we will allow members to refill their prescription early through an emergency refill at their local pharmacy. The pharmacist will be able to submit the request for an emergency refill on the member's behalf.
- However, consistent with CDC recommendations, we have advised members against "stockpiling" medication unnecessarily. Rather than obtaining multiple 30-day refills, we are encouraging our members to take advantage of their ability to obtain a 90-day supply through our mail order program or one of our approved retail pharmacies.

How long will this policy be in place?

- Given the dynamic nature of the current environment, it is difficult to estimate how long this policy might need to be in effect.
- We will continue to monitor the situation and will make appropriate changes as time goes on.

Does this apply to all members?
Yes. Except where prohibited by local regulations, this will apply to all members.

Is there a member cost for the early refill?
The member will be responsible for the member cost share amount specified by their plan.

Does this apply to all medications?
No. Except where prohibited by local regulations, restrictions will still be in place for controlled substances such as opioids.

Does this apply to specialty drugs?
Yes. Members will be able to refill early and get a 30-day supply if they are concerned about having enough medication on hand.

Isn't this change promoting stockpiling of drugs?

- We continue to reinforce the guidance, as supported by CDC recommendations, that individuals should not stockpile prescription medications.
- That said, we believe that it is critically important that individuals continue to take their medications as prescribed by their doctor. We will continue to take steps to support our members in their efforts to do so in a manner that is safe and effective.
- We believe that this policy, particularly in light of the President's emergency declaration, is consistent with that approach and we will monitor utilization patterns to identify any refill behavior that seems irregular.

Can a client opt out of this?
No. Due to the complexities associated with allowing individual employer groups to opt out of this, along with the need to comply with government policies, we cannot allow individual employer groups to opt out of this decision.

Will the early refill policy increase cost? Who will cover the cost associated with the additional refills?

- While this could increase costs in the short run as a result of people filling prescriptions earlier than anticipated, it is our hope that these costs will be offset by a member not needing to fill a prescription down the road.
- [Fully insured customers] Members will still be responsible for their normal cost share and Empire will cover the plan costs associated with any prescription refills.
- [ASO customers] Members will still be responsible for their normal cost share and the employer plan will cover the plan costs associated with any prescription refills.

What are you doing to ensure that this policy doesn't get abused?

We will be monitoring utilization to identify any irregular refill patterns among members and pharmacies and will take steps to intervene should any concerns arise.

In addition, where allowed by local regulations, there is a maximum limit of one early refill in a 180-day period.

As a result of COVID-19, the Drug Enforcement Agency is now allowing telemedicine providers to issue prescriptions for controlled substances. What controls does Empire have in place to prevent abuse?

- On March 16th, the DEA, in coordination with the Secretary of Health & Human Services, announced that it was temporarily waiving the in-person exam restrictions on the prescribing of controlled substances (schedule II-V) via telemedicine.
- Empire, and its PBM IngenioRx, will follow the directives from HHS and the DEA, as well as any superseding local regulations, related to this issue.
- Empire was an early leader in the area of implementing pharmacy controls to prevent the misuse and abuse of controlled substances such as opioids and, as a result of our actions, we have reduced opioid utilization among our membership by more than 50 percent since 2015.
- These controls include limiting initial prescriptions for short-acting opioids to no more than a seven-day supply, prior authorization requirements for all long acting opioids and short-acting opioids exceeding a fourteen day

supply in a 30-day period, quantity limits on nearly all controlled substances, prior authorizations on stimulants such as ADHD drugs, and more.
- Given the significant positive impact that these, and other controls, have had on managing the use of controlled substances we do not, at the present time, have plans to implement any new, telemedicine-specific controls.

How do members obtain a 90-day supply of their maintenance medication?

- If members do not currently have a prescription for a 90-day supply, they should contact their physician to determine whether a 90-day supply is appropriate for you.
- If their physician believes that a 90-day supply is right for them, they can send IngenioRx home delivery an electronic prescription, fax the prescription to 800-378-0323, or call it in to the home delivery pharmacy at 833-203-1742.

If a plan allows 90-day supplies, can members get a 90-day supply of any medication?

No. We are unable to fill 90-day supplies of specialty medications and controlled substances such as opioids. In addition, to obtain a 90-day supply a member's physician must approve and write a prescription specifically for a 90-day supply.

Why can't members get a 90-day supply of their specialty medication?

- Specialty medications are particularly complex when it comes to dosing and potential side effects. As a result, individuals taking these medications require a higher degree of monitoring to ensure that the therapy is having the intended result and that it is well tolerated.
- Because of this, treatment approaches (dose, medication selected, duration, etc.) can change quickly. As a result, we limit specialty prescriptions to no more than 30-days.
- We continue to monitor for potential disruptions to the pharmacy supply chain and delivery logistics. At the present time, we have not identified any issues and feel confident that our specialty patients will continue to be able

to receive those medications. We will continue monitor and should these conditions change we will adjust accordingly.

Do you charge for home delivery?

- No. 90-day prescriptions filled through the IngenioRx Home Delivery pharmacy receive free standard shipping.
- Members can also check with their local pharmacies for delivery options they may offer.

What kind of packaging are your home delivery prescriptions shipped in?

Our existing packaging materials include poly bags and cardboard boxes.

Can coronavirus live on packages? Is getting prescriptions through the mail safe?

- Although we are still learning about COVID-19 and how it spreads, both the WHO and CDC have stated that the likelihood of an infected person contaminating commercial goods is low and the risk of catching the virus that causes COVID-19 from a package that has been moved, travelled, and exposed to different conditions and temperature is also low.
- As a general precaution, members should wash their hands for 20 seconds with soap and water after bringing in packages, or after trips to the grocery store or other places where you may have come into contact with infected surfaces.

Who do you use to ship your home delivery prescriptions?

- We primarily use the US Postal Service and UPS to ship our home delivery packages but we have relationships with all of the major carriers.
- In the event that one of our carriers shuts down deliveries, we have redundancy plans in place to move our shipments to another carrier.

Can my home delivery prescription be delivered without requiring a signature?

Given guidance regarding social distancing, we are waiving our requirements for a signature at the time of delivery for home delivery prescriptions except where required by local regulations.

What do you have in place to keep your dispensing facilities "clean" of COVID-19?

- In order to ensure that our dispensing facilities are safe and sanitized to minimize exposure risk, we are following the CDC's general cleaning guidance, which includes frequently cleaning all commonly touched surfaces, using disposable wipes to disinfect these surfaces, and using Personal Protective Equipment while cleaning.
- Additionally, we are instituting more stringent cleaning protocols in keeping with the recommendations from the CDC. Cleaning crews will be on-site daily to disinfect surfaces in common areas and lavatories.

How are you handling prior authorizations on elective or outpatient procedures during the COVID-19 crisis?

- To ensure that our members do not experience any interruptions in their medication therapy, we will be extending expiring prior authorizations, where appropriate, on a rolling basis for an additional 180 days.
- This policy is in effect from March 1 through May 30, 2020.
- Prior authorizations after May 30, 2020 will return to the usual timeline.

Does or will Empire/IngenioRx have a "Discount Card" program available to those whose coverage terminates?

- Addressing access and affordability is central to our mission.
- We currently have prescription discount programs that are added as a value added feature of some of our medical plans and these discounts would continue be available to those individuals even if they lost their medical coverage.
- That said, given the current environment, we are actively working on opportunities to broaden the reach of our prescription discount programs to include more members and general consumers and will share more once those programs are available.

How is Empire covering pharmacist-ordered and administered COVID-19 testing?

There are two ways that pharmacist-ordered and administered COVID-19 testing can be paid.

- Large retail chain pharmacies have partnered with the U.S. Department of Health and Human Services to cover the cost of COVID-19 tests administered by retail pharmacies in a variety of new locations, including "parking lot" test sites. These pharmacies will bill the government to cover the cost of these tests. Empire will not cover these tests.
- Empire will cover a COVID-19 test ordered and administered by a pharmacist when acting in accordance with state requirements. Coverage is available with cost shares waived when the test is administered when medically appropriate for the care of the member. Coverage is not designed to provide payment for tests administered for broad public health purposes. Claims for COVID-19 tests are being processed through members' medical benefits, not their pharmacy benefits.

Behavioral Health Questions

What is Empire doing to support behavioral health and emotional wellness during COVID-19?

To meet the needs of Empire members who may be struggling during this time, Empire is promoting digital solutions to help.

- Empire's affiliated health plans and Beacon Health Options are collaborating with Psych Hub, mental health advocates and other national health insurers to develop a free digital resource site to help individuals and care providers address behavioral health needs resulting from the COVID-19 pandemic.
- Empire is providing full access for all members to our Employee Assistance Program web site with COVID-19 tools and informational resources (click log-in, enter company code: EAP Can Help).

- Empire is increasing the ability of providers to deliver behavioral health services via the telephone and encouraging members to use existing telehealth services for behavioral health, as well as to embrace services delivered digitally.
- Empire health plans with Employee Assistance Programs offer individual and employer-sponsored members up to six free sessions with a behavioral health counselor.

Empire's telehealth provider, LiveHealth Online, offers LiveHealth Online Psychology and LiveHealth Online Psychiatry, a confidential and effective way for members to see a behavioral health professional, such as a therapist, psychologist or psychiatrist, during these stressful times and receive behavioral health support from their homes via smart phone, tablet or computer-enabled web cam.

In addition, myStrength is an app that delivers 24/7 access to personalized online and mobile resources to help members manage symptoms such as stress, anxiety, depression, substance use, chronic pain and sleep. myStrength was already available to members who have Empire's Employee Assistance Program, other employer-based programs and Medicaid members in Florida, Texas, Washington and Washington D.C.

What behavioral health services is Anthem offering that have waived cost shares?

From March 17 through Sept. 30, 2020, Anthem is waiving member cost share for telehealth visits, including visits for behavioral health, for members of our employer-sponsored, individual, and Medicare Advantage plans, and where permissible, Medicaid plans. Cost share waivers may vary for members who have self-insured plans, which have the ability to opt-in to member cost share waivers

How can Empire's Employee Assistance Programs assist members at this time?

Empire health plans offer most individual and employer-sponsored members up to six free sessions with a behavioral health counselor that they access through an Employee Assistance Program. EAPs are a good tool to help ease members into behavioral health sessions. After that, their health benefit plans offer standard coverage for behavioral health sessions. EAP can help with assessing symptoms, discussing treatment options, and helping members connect to support and

resources, such as myStrength, an app which delivers 24/7 access to personalized online and mobile resources to help members manage symptoms of depression, anxiety, substance use, stress, chronic pain and sleep.

What kind of behavioral health philanthropic or social determinant of health efforts have you been engaged in related to COVID-19?

Through the support of Empire's philanthropic arm, the Empire Foundation, a $100,000 grant was made to Mental Health America, which supports MHA's Screening to Supports program. The program is an online platform offering free, anonymous mental health screens to nearly 1 million people per year.

Also, Empire has partnered with Aunt Bertha, a leading social care network providing community support across the country, to help our members identify free and reduced-cost programs to meet their needs. Programs include help with food, transportation, health, housing, job training and a range of other initiatives that can assist individuals and families throughout the COVID-19 crisis.

Is Empire maintaining mental health parity with medical treatment when it waives member cost shares for medical treatment of COVID-19?

Yes. Temporarily waiving cost shares on COVID-19 treatment does not violate mental health parity. Empire health plans took these actions to assist members facing a pandemic and the waivers are specific to the treatment of the disease, except for telehealth visits, where we are waiving cost shares for both medical and behavioral health services. These waivers may result in future changes to cost-shares when quantitative treatment limitation (QTL) testing is conducted, but that does not impact mental health parity compliance for current claim processing. We are also approaching the Department of Labor to see if they can grant an exception to including COVID claims in the QTL analysis.

BEACON

What is Beacon doing to support behavioral health and emotional wellness during COVID-19?

At the heart of everything Beacon does is helping people live their lives to the fullest. During these challenging times we are enabling this through a variety of

initiatives including our ongoing employer/member outreach to ensure our counseling, wellness, life coaching, etc. programs are available.
Beacon Health Options has developed a resource site which includes tips, videos, podcasts and webinars for helping adults and children cope with anxiety and stress during a pandemic; living with uncertainty; how to conquer fear and anxiety; coping with stress during infectious outbreaks; dealing with overwhelming media coverage and more. Providers can access topics such as how to avoid burnout as well as state-specific operating guidelines. While clients may review a variety of useful tips for their employees or plan members.

What behavioral health services is Beacon offering that have waived cost shares?
During this time of public health emergency, in order to ensure access to care for our members, most plans will waive cost sharing for routine outpatient telehealth and for all ABA services. Members covered by self-funded employer sponsored plans and some commercial and government health plans will continue to follow the plans' guidelines and policies which may not waive cost shares.

How can Beacon's Wellbeing/EAP assist members at this time?
COVID-19 and its associated issues are causing pressing personal problems for employees. An ongoing survey of more than 80,000 people from survey provider SurveyMonkey found that 86 percent of Americans are worried about the outbreak in the U.S. Every year, 18 percent of U.S. workers experience some type of mental health problem and the National Institute of Mental Health reports that depression is the leading cause of workplace absenteeism.
Beacon's Wellbeing plans help employees live healthier, more productive lives by making it easier to get help in the way that's most meaningful for the individual – via web, chat, phone or digital app. Those services include counseling on a variety of issues; legal/financial coaching; work/life services to balance the lives of employees; and online wellness coaching.

Underwriting and Financial Questions

If participation falls below our Underwriting threshold will we re-rate the group?
Effective through July 31, 2020, if the decrease in participation is a result of the COVID-19 crisis, rates and premiums will not change.

Will the probationary period for new hires be waived?
Employees who are rehired by Sept. 30, 2020 will not be subject to the waiting period. Newly hired employees will be subject to the waiting period.

If a small group currently offers multiple plan designs, and does not want to add another, will Empire allow a current insured employee to change from a richer plan to a less expensive plan?
Yes, a current ACA insured employee can buy down their plan design until May 31, 2020. The employer should review their cafeteria plan document for qualifying event options.

Can an employer add a new plan design during the policy period?

- Small Group ACA groups can add one new plan design off-cycle as long as the new plan is less expensive than the least expensive plan currently offered. Employers must notify Empire by May 31, 2020 for a future off-cycle buy down effective date that is no later than July 1, 2020. Empire will implement the off-cycle buy down within a minimum of 10 business days. The group will keep their current renewal date.
- Small Group and Large Group Empire Balanced Funded accounts and Key business (51-100) can add one new plan design off-cycle as long as the new plan is less expensive than the least expensive plan currently offered. Employers must notify Empire by May 31, 2020 for a future off-cycle buy down effective date that is no later than July 1, 2020. Empire will implement the off-cycle buy down within a minimum of 10 business days. The group will keep their current renewal date.
- Large Group ASO and Fully Insured accounts can potentially add a new plan design off-cycle, but these are subject to approval by the state Underwriting RVP.

- Small Group legacy (non-ACA) groups cannot add a new plan design off-cycle due to concerns with piercing grandmothered status.

Can the group retain their current plan(s) if they add a new plan off-cycle?
Yes, the group can retain their current plan(s) as well as the new plan design.

If an employer offers multiple plan options and does not add a new less expensive plan design, will Empire allow employees to switch plans?
Empire will allow currently covered employees to switch to a lower priced option if one is offered. This is not considered to be an open enrollment. This option is available for a May 1, 2020, June 1, 2020, July 1, 2020 or Aug. 1, 2020 effective date. No retrospective plan changes will be allowed. The amount of the deductible and out-of-pocket max that has already been met will accumulate towards the deductible and out of pocket maximum in the less expensive plan design that the employees switch to. For groups undergoing a system migration it may take longer than ten days to implement the accumulators. Note that the employer should review their cafeteria plan document for qualifying event options to ensure compliance.

What is Empire's position on IRS Notice 2029-29 regarding §125 Cafeteria Plans? Specifically, will Empire cover members when their employers permit them to make Cafeteria plan mid-year election change, even absent a change in status or other IRS-recognized event?
Empire will allow members who had previously waived coverage to enroll in a plan through Aug. 1, 2020, even absent a qualifying event. This option is available to both fully-insured and self-funded groups, excluding life and disability coverage. These members would be covered under Empire's stop loss policy, but if Empire is not the stop loss carrier, we recommend verifying coverage with the customer's stop loss carrier.
Empire will also allow currently covered employees to switch to a lower priced medical plan when one is offered. This option is available for July 1, 2020 and Aug. 1, 2020 effective dates. We will not allow currently covered employees to switch to a more expensive plan absent a qualifying event as described in the benefit booklet or certificate or as mandated by HIPAA.

If an employee waived coverage for this plan year, would Anthem allow a special open enrollment?

Yes, Anthem will provide both Fully Insured and Self-funded groups, excluding Life and Disability*, an option to offer a Special Enrollment Period to enroll employees who previously did not elect to enroll in coverage at the time of open enrollment. This Group Special Enrollment Period will last from June 8, 2020 to July 31, 2020 and is available to both Large and Small groups. Coverage would be effective no later than Aug. 1, 2020. State eligibility guidelines will apply. Employers should consult their legal counsel regarding the tax treatment of employee coverage elections made through this SEP.

Employees needed to be eligible at the time of open enrollment for the employer. This Group Special Enrollment will also be applicable to dependents even if the employee currently has coverage. Employers should follow standard processes of sending updated enrollment to Anthem as they would for any qualifying event or enrollment period via 834s and paper. Other electronic formats are not available at this time.

*For Anthem's Fully Insured Group Life and Fully Insured Group Disability groups, the Special Enrollment Period will not apply. The existing enrolled Disability and Life population shall remain covered, subject to the all other terms of the policy.

If an employer adds a new less expensive plan design, will Empire allow employees to switch plans?

Yes. If the group adds a new plan and only allows employees to switch to that plan, this is considered an open enrollment that will be available to all employees, even those who had previously waived coverage. Employees switching plan designs or initially enrolling are only allowed to enroll in the new, least expensive plan. The amount of the deductible and out of pocket max that has already been met will accumulate towards the deductible and out of pocket maximum in the less expensive plan design that the employees switch to. For groups undergoing a system migration it may take longer than ten days to implement the accumulators.

Would Empire allow an employer to add a new plan and permit employees to choose that new plan or other plans that were already offered?
Empire will allow currently covered employees to switch to any of the lower priced options. This is considered to be an open enrollment that will be available to all employees, even those that had previously waived coverage. However, absent a qualifying life event, the employees who had waived coverage are only allowed to enroll in the new, least expensive plan.
This option is available for a May 1, 2020, or June 1, 2020 or July 1, 2020 effective date. No retrospective plan changes will be allowed. The amount of the deductible and out of pocket max that has already been met will accumulate towards the deductible and out of pocket maximum in the less expensive plan design that the employees switch to. For groups undergoing a system migration it may take longer than ten days to implement the accumulators.
Note that the employer should review their cafeteria plan document for qualifying event options to ensure compliance.

What types of products does the small group off-cycle buy down apply to?
This applies to ACA plans only.

What is Empire's grace period position for state and federal mandates?
Empire is and will remain compliant with all state and federal grace period mandates.

Flexible Spending Accounts/Workers' Comp/Other Benefits Questions

How are we handling allowing members to make changes to their FSA for dependent care?
Elections to a dependent care FSA can be increased or decreased when members experience a change in cost or coverage. That is just the IRS term for being allowed to modify your election if daycare becomes more/less expensive or now is/is not needed. Healthcare and Limited Purpose FSAs are more complicated and do not have the change in cost or coverage allowance under Sec 125 cafeteria plans.

Currently, Dependent Care accounts require a signature from the daycare provider. In light of the current signature, we have been asked to remove this requirement while daycare centers are closed. Would this cause any untoward impacts from a regulatory perspective?

Empire has changed the DCA reimbursement form to not require a signature in most cases. If the member has an invoice from the provider we can use that as evidence for substantiation. However, if no invoice is available then substantiation guidelines would require a provider signature. The federal government has not lifted or suspended any substantiation requirements at this time so one or the other is needed. Members are able to reimburse themselves in the future once centers are open again, and employers are able to extend runout periods, for plan years changing over in the near future, to give employees more time to file claims.

Can customers change Dependent Care FSA elections because childcare providers are closed or they are now working from home?

Generally Dependent Care elections cannot be changed mid-plan year unless the subscriber is eligible as part of a qualified life event. Under some circumstances, election changes can be made as the result of a change in cost or coverage. Employers should review their cafeteria plan documents and determine if Dependent Care election changes can be made as a result of a change in cost or coverage due to emergency measures enacted because of COVID-19.

Will there be any changes to substantiation requirements for FSA and HRA reimbursements?

Current regulations have not changed the requirement that all FSA and HRA transactions be substantiated by proper documentation. If, in the future the IRS grants substantiation relief, then Empire will review and take appropriate action. Empire realizes that COVID-19 has created a time where the need to obtain care is at its greatest, while at the same time, the ability to substantiate that care is more difficult.

What relief is available for customers unable to submit runout claims because documentation is unavailable due to provider closures?

Spending account runout periods are established by the employer when setting up the plans. As such, plan designs can be amended allowing for extended time to submit prior period claims. In the event the current runout period closes prior to implementing an extension, the employer is permitted to make the plan design changes to reopen the runout period and allow eligible expenses to be resubmitted for reimbursement.

Can customers make changes to FSA elections because elective and nonessential services have been halted?

At this time FSA and cafeteria plan regulations do not allow for election changes due to cost or availability of services. Empire will continue to provide updates on any regulatory changes that give relief to subscribers that are unable to use their full FSA elections. Employers that currently do not offer grace period or rollover as part of their FSA plans are able to add those features to extend the time period for using FSA funds and lesson some of the impact of FSA forfeitures.

As many gyms have closed due to COVID-19, how will this impact the number of gym visits needed for reimbursement?

We are finalizing a waiver approach with American Specialty Health now to ensure no disruption to members seeking gym reimbursement while they are unable to access their facility.

Workers' Compensation

If employees, such as doctors, nurses and firefighters, are required to work during the COVID-19 pandemic and contract COVID-19 while at work, are the claims considered Workers' Compensation claims or employer medical plan claims?

Numerous states have recently issued rules or directives establishing a presumption that COVID-19 related injuries or deaths are work related for certain employees and, thus, compensable under the Workers' Compensation system. These presumptions can be either rebuttable or conclusive and vary by state. The COVID-19 positive employees covered by these rules also vary widely from state to state; some states only cover specific frontline or essential workers while other states include all employees required by their employers to work outside

the home. Most Anthem medical plans include an exclusion for injuries which are work related or Workers' Compensation compensable. Anthem intends to follow its established subrogation process on medical claims where liability falls on another party or otherwise transfer claims liability to the Workers' Compensation system in accordance with these state rules or directives regarding COVID-19.

Benefit Impact for Layoffs/Furloughs

Will Empire be cancelling policies for members with Individual plans if they can't pay their premium because they lost their job?

As the COVID-19 continues to threaten public health and impacts the ability for many members to pay their premiums due to loss of employment, we are providing members additional time to pay their premiums.

The following applies to members enrolled in the following products:

Non-subsidized Individual members: Individual members will not have their policies cancelled in June due to non-payment of April or May premiums and those members will have until June 30 to pay their premiums. Individual members who are still delinquent with their March premium will have their policies cancelled in early June.

ACA subsidized Individual Policies (with financial assistance)

- Individual members enrolled in ACA plans with financial assistance who would normally enter into the first month of their 90-day grace period as of April 1 due to not paying their portion of the premium due on April 1 will receive an additional 30 days to pay their portion of the premiums before actually entering the first month of the 90-day grace period. Members who have not paid their premiums in full by May 1 will enter into the first month of the 90-day grace period. Any members enrolled in ACA compliant plans with APTC who are already in the 90-day grace period are required to pay their portion of the premiums that are due before the end of the 90-day grace period to avoid cancellation.

The duration of this policy will continue to be reviewed. State specific guidance for our Individual members as well as guidance for our members receiving federal financial assistance will be communicated when available.

The effective date of any termination will depend on state law (e.g., either paid through date or end of statutory grace period).

Are customers able to continue employee health benefits if part of the workforce is laid-off or furloughed in response to the COVID-19 crisis?

Fully Insured Plans	Self-Insured Plans
Yes. Empire's requirement for employees to be actively working in order to be eligible for coverage will be relaxed through Sept. 30, 2020 as long as the monthly premium payment is received. Coverage must be offered on a uniform, non-discriminatory basis to all employees and employee premium contributions must be the same or less than what they were prior to the layoffs.	Yes. Payment of administrative fees, claims cost and stop loss premium is required to continue coverage for laid-off and furloughed employees who are not actively at work. This flexibility will remain in place through Sept. 30, 2020. Coverage must be offered on a uniform, non-discriminatory basis to all employees and employee premium contributions must be the same or less than what they were prior to the layoffs. If Empire is not a customer's stop loss carrier, Empire recommends verifying coverage with the customer stop loss carrier.

Are customers able to continue employee health benefits if the entire workforce is laid off or furloughed in response to the COVID-19 crisis?

Fully Insured Plans	Self-Insured Plans

Yes. If one person remains actively employed and continues health benefit coverage, all employees laid-off will be eligible for coverage through Sept. 30, 2020, as long as the monthly premium payment is received. Coverage must be offered on a uniform, non-discriminatory basis to all employees and employee premium contributions must be the same or less than what they were prior to the layoffs.	Yes. If one person remains actively employed and continues health benefit coverage, all employees laid-off will be eligible for coverage through Sept. 30, 2020. Payment of administrative fees, claims cost and stop loss premium is required to continue coverage for laid-off employees who are not actively at work. Coverage must be offered on a uniform, non-discriminatory basis to all employees and employee premium contributions must be the same or less than what they were prior to the layoffs. If Empire is not a customer's stop loss carrier, Empire recommends verifying coverage with the customer's stop loss carrier.

Will continuation coverage be available for a customer's employees who have been laid off and are employers able to offer continuation coverage to their employees at their own expense?

Fully Insured Plans	Self-Insured Plans
If an employer offers COBRA and if one person remains actively employed, employees may elect to continue coverage under COBRA by following the normal notice and election procedures. If there are no active employees, the plan is terminated and COBRA will not be an option. However, employees will have the option to enroll in individual coverage during a special enrollment period.	If a customer offers COBRA and if one person remains actively employed, employees may elect to continue coverage under COBRA by following the normal notice and election procedures. If there are no active employees, the plan is terminated and COBRA will not be an option. However, employees will have the option to enroll in individual coverage during a special enrollment period. If Empire is a customer's stop loss carrier, the policy will terminate if the minimum enrollment of active employees threshold is not met. If Empire is not a customer's stop loss carrier, Empire recommends verifying coverage and minimum enrollment requires with your stop loss carrier.

As an employer, are we able to continue to offer health benefits to our employees if their hours are significantly reduced in response to the COVID-19 crisis? In other words, if only employees that work 30+ hours are eligible for coverage, will they still be eligible if they work less than 30 hours per week?

Fully Insured Plans	Self-Insured Plans
For groups with 101+ employees Yes. Empire will continue to provide coverage through July 31, 2020 in this situation as long as the monthly premium payment is received. *For groups with 1-100 employees:* An employee must work a minimum of 20 hours to be eligible for coverage. Empire will continue to provide coverage through May 31, 2020 in this situation as long as the monthly premium is received. Coverage must be offered on a uniform, non-discriminatory basis to all employees that had been offered coverage and employee premium contributions must be the same or less than what they were prior to the reduction in hours.	Yes. Payment of administrative fees, claims cost and stop loss premium is required to continue coverage for employees that are no longer working full-time hours. This exception will be made through May 31, 2020. Coverage must be offered on a uniform, non-discriminatory basis to all employees that had been offered coverage and employee premium contributions must be the same or less prior than what they were prior to the reduction in hours. If Empire is not your stop loss carrier, Empire recommends verifying coverage with your stop loss carrier.

Will Empire allow coverage reinstatement for failure to pay premium?
At this point in time, Empire's current reinstatement policies will remain in place.

Will employer rates/premium be subject to change if enrollment drops by more than 10 percent as a result of the COVID-19 crisis?
Effective through July 31, 2020, if the loss of enrollment is a result of the COVID-19 crisis, rates and premiums will not change.

This increases Empire's risk, but is an appropriate measure to take in the near-term given the difficult and unique situation our customers are facing.

As a result of the COVID-19 crisis, will Empire renewal rate actions or quote responses be delayed?
Empire is committed to delivering our renewals within our normal schedule and meeting deadlines on delivery of quotes.

If laid-off employees lose their health insurance coverage, will Empire be able to offer coverage options?
Empire recommends employers work with their employees to assess coverage options and eligibility by going to www.healthcare.gov. Some examples of options include Medicaid or qualifying event for a special enrollment period for an ACA compliant plan.

What happens to claims and the members' insurance coverage when members are either unable to pay their Individual premiums or their employers have problems paying their group premiums?
When payment is received, and the claim has been finalized, the member will receive an Explanation of Benefits, or EOB, notification. If members have online access, they can see the final status in the Sydney Health App or on www.empireblue.com.

For those who enroll in an ACA compliant health insurance plan, how quickly will their coverage be effective?
The qualifying event for the special enrollment period will determine the effective date of coverage. Please visit www.healthcare.gov or prospective carrier. Premium subsidies are not available for plans purchased outside of the exchange.

How long can an employer keep an employee on the plan if the employee is on a leave of absence?
The duration an employer can keep an employee on the plan while currently on a leave of absence is based on the employer's leave of absence policy.

If an employee is unable to contribute coverage through payroll due to lack of income, will Empire provide relief to the member?
No. At this point in time, Empire's current policies will remain in place.

If companies that have to temporarily shut down due to COVID-19 and are in the middle of open enrollment or have an upcoming open enrollment, will Empire extend their open enrollment period?
Empire will continue to allow policy changes to be made 60 days after the renewal date.

Are we able to place high dollar claims on hold or stop if the self-insured group believes that it might not have the funding at this time?
We realize these are unprecedented times and want to help and support our clients where possible. However, due to the various impacts to all customers, Empire will not be able to place high-dollar claims on hold.

Would Empire be open to delegating decision-making authority on eligibility to the Professional Employer Organization?
Effective through July 31, 2020, we will allow the Professional Employer Organization, or PEO, to have decision-making authority upon request for these arrangements.

What is Anthem's policy for reinstating employees who were terminated or furloughed and lost coverage?
If employee is rehired or converted to actively at work within 60 days of termination or date of furlough (in normal times it is 30 days, but we will extend to 60 days for enrollment receipt dates through Sept. 30, 2020), the standard will be to reinstate as of the original effective date. This means:

- No break in coverage
- Employer responsible for back-payment of one or two months of premium
- Deductible and OOP accumulators do not reset – it is as if the member never left the plan at all

If employee is rehired or converted to actively at work within 60 days of termination or date of furlough and the employer's eligibility rules do not permit the employee to be reinstated as of the original effective date:

- Employer will need to let us know what effective date to use – would either be rehire date or some date in the future
- Employer not responsible for back-payment of premium
- Results in break in coverage
- Deductible and OOP accumulators reset, unless terms of benefit booklet or certificate specifically state otherwise

If employee is rehired or converted to actively at work between 61-92 days (or 61-365 days for Maine groups) of termination:

- Employee will not need to satisfy the waiting period again
- Employer will need to let us know what effective date to use – would either be rehire date or some date in the future
- Employer not responsible for back-payment of premium
- Results in break in coverage
- Deductible and OOP accumulators reset, unless terms of benefit booklet or certificate specifically state otherwise
- If employee is rehired after the expiration of the periods above, the answers are the same, except the employee will need to satisfy any applicable waiting period, or where permitted, join via an earlier open enrollment period.

Note that Employer Access/Portal is not designed to process requests outside of the normal processes. All COVID-19 rehire requests must be submitted via paper. The employer must clearly state on the application/spreadsheet or email that the request is due to Qualifying Event: COVID-19.

If an employee waived coverage for this plan year, would Empire allow a special open enrollment?

Yes, Empire will provide Fully Insured Groups, excluding Life and Disability^, a Special Enrollment Period to enroll employees who previously did not elect to enroll in coverage at the time of open enrollment. This Group Special Enrollment Period will last from March 23, 2020 to April 15, 2020 and is available to both Large and Small groups. Coverage would be effective April 1, 2020. State eligibility guidelines will apply. Employers should consult their legal counsel regarding the tax treatment of employee coverage elections made through this SEP.

Employees needed to be eligible at time of open enrollment for the employer and this Group Special Enrollment will also be applicable to dependents (even if the employee currently has coverage). The employer should follow standard processes of sending updated enrollment to Empire as they would for any qualifying event or enrollment period via 834s and paper; other electronic formats are not available at this time. Updated enrollment needs to be received by Empire by April 20, 2020 at the latest.

This is for Fully Insured groups. For ASO groups, it is their decision as to what guidelines they would like to apply.

^For Anthem's Fully Insured Group Life and Fully Insured Group Disability groups, the Special Enrollment Period will not apply. The existing enrolled Disability and Life population shall remain covered, subject to the all other terms of the policy

Individuals have a special enrollment period that will last from March 23 through May 15. During this time, eligible individuals may enroll on a direct payment plan on the NY State of Health Exchange or directly with an insurer.

How will Empire handle broker commission payments if extended grace periods are provided to the group?
There will be no change to Empire's current broker commission practices.

Employer Impact Questions

Why is it important to refer to the CDC for questions related to COVID-19?
The COVID-19 outbreak is an emerging, rapidly evolving situation and CDC provides updated information as it becomes available, in addition to updated guidance.

The CDC is an official, public and national source of information and acts as a clearinghouse for information and reporting on infectious disease as it is constantly evolving. As part of the US Department of Health and Human Services, its mission is to protect America from health, safety and security threats, both foreign and in the United States.

What can employers do?
Employers should check the CDC page for interim guidance for businesses and employers for information on strategies that can be used to prevent the spread of COVID-19 and keep employees safe.

Should employees be traveling?
That is a decision to be made by each individual business as risk will vary as to the type of business and over time as the virus evolves. The CDC has established a travelers' health page to keep everyone updated on where travel has its greatest risks.

What is social distancing and where can I find out more about it?
Social distancing measures are taken to restrict when and where people can gather to stop or slow the spread of infectious disease. The CDC has published a set of recommendations on its interim guidance for businesses and employers page that can help with that.

How can employers communicate about COVID-19 without causing social stigma?
Stigma is a real concern. Viruses cannot target people from specific populations, ethnicities or racial backgrounds. The CDC has developed a page on stigma related to COVID-19 that may help employers mitigate this issue.

How does my business prepare for a pandemic?
The CDC pages for interim guidance for businesses and employers have helpful information.

How does the CDC recommend local governments and communities prepare for a pandemic?
The CDC has developed pandemic preparedness resources that are available here.

How will Empire address open enrollment over the next several months for clients who do not have online resources?

The team is developing virtual open enrollment options and will share them when available. Members can call the number on the back of their identification card to confirm coverage.

Should employers be keeping their own test kits? Should they be bringing in nurses to screen?
Customers should not procure their own tests for COVID-19. Members should contact their regular medical provider, LiveHealth Online, or our 24/7 NurseLine.

If a customer wanted to perform its own screenings, could Empire provide a nurse or other resource at our locations at a cost?
We recommend that customers not establish screening on their premises. If members need to be screened or tested, we recommend they contact their regular medical provider, use LiveHealth Online, or our 24/7 NurseLine.

Disability, Absence, Life and Supplemental Health Questions

Life and disability plans available from our affiliate, Anthem Life & Disability Insurance Company (Anthem Life).

Are premiums required on voluntary (life, AD&D, disability and/or supplemental health products) coverage?
Yes, premiums are required to continue coverage. Employers are required to collect and remit premiums from their employees. Non-payment of premium will result in termination of coverage.

Can the employer pay the premium on behalf of the employee?
Yes.

Are there any imputed income issues?
Plan sponsors are encouraged to address tax and other plan issues with their own legal counsel.

Will Disability or Life rates/premiums be subject to change if enrollment drops by more than 10 percent as a result of the COVID-19 crisis?
Effective through July 31, 2020, if the loss of enrollment is a result of the COVID-19 crisis, rates and premiums will not change solely as a result of the COVID-19 loss of enrollment.

Disability Plans

Is an individual who is quarantined but not sick or diagnosed with COVID-19 considered disabled?
Generally, we do not consider quarantined workers to be disabled unless they have a medical condition that results in restrictions and limitations that satisfy a policy's definition of disability. Employees who have been diagnosed with COVID-19 and are unable to work will be evaluated like any other injury or illness under the contract, with clinical support/proof of disability required. All contract provisions apply.

Is isolation or quarantine considered a disability under Anthem's disability insurance or life insurance waiver of premium provisions?

- For fully insured groups, each case will be reviewed on its own merit, subject to the policy provisions of the disability or life policy. Employees who self-quarantine but are not diagnosed with COVID-19 will not be covered.
- For self-insured groups, we will coordinate with the policyholder.

Does Anthem have a quarantine rider on its disability plans?
Anthem does not have a quarantine rider on disability plans.

How will Anthem use tele-doctor/virtual doctor office visits to get documentation/medical records/certification of disability?
If LiveHealth Online is used, Anthem disability case managers may be able to access the claimant's summary through Anthem's clinical integration application. When another telehealth is used, Anthem will utilize the summary given to the employee/claimant by the telehealth provider.

What if we are unable to obtain medical documentation to certify or recertify a disability, such as doctor's office is closed, doctor unable to see nonessential or non-emergency patients.

We will make every attempt to obtain medical records. In the event we are unsuccessful, we will review the claim history, utilize duration tools, and interview the claimant to determine next steps. For customers that have Anthem medical and disability coverage, we may be able to utilize in-house medical information, with claimant's authorization.

What happens if an employer closes their facility and employees are unable to work?

Employees who are unable to work as a result of their employer's decision to close a facility do not meet the definition of disability under our policy. Employers remain responsible for decisions related to employee wages.

Continuation of Coverage

Can employees continue their group disability or group life coverage if their employer closes their facility and employees are unable to work?

Depending upon each group policy, coverage may continue but will be subject to the terms outlined in the policy that relate to temporary layoffs and leaves of absence. Furloughs, if not defined in the policy, will be treated as temporary layoffs and the corresponding policy terms will apply.

For continuance of coverage, premium must continue to be paid, without interruption.

Will we relax the 31 day timeframe for conversion and portability options for employees who are being laid off due to COVID-19?

Conversion and portability timeframes are stated in the contract. We will apply the provisions of the contract. If the provisions in the contract create a hardship, please contact our conversion and portability department for assistance.

If employees decide to drop voluntary coverage because they can't continue premiums, can they reapply later?

Yes, employees who drop coverage but are still employed by the employer can re-apply for coverage at a later time. Employees may need to wait until the next annual enrollment to re-enroll depending upon the plan.

Will the employees who dropped voluntary coverage because they can't continue premiums be subject to Evidence of Insurability?
The employee may be required to submit EOI depending upon enrollment rules for late entrants to the plan, but would not need to satisfy a new service waiting period.

Will the employees who dropped voluntary coverage because they can't continue premiums be subject to pre-ex for Voluntary STD or LTD upon re-enrollment?
Yes, pre-existing condition limitations would apply for Voluntary Short-term Disability and Long-term Disability re-enrollment according to plan provisions, even if the employee previously satisfied the pre-existing condition limitation.

If the employer decides to temporarily drop coverage for all or some of its employees, and these employees remain employed by the employer, can the employer reinstate coverage at a later date?
Yes, employers can reinstate coverage. Our underwriting and sales team will work with the employer and broker to review updated census and plan design.

Is an employee eligible for life and/or disability benefits if their hours are reduced below the minimum hours required for eligibility as defined in the policy?
If an employee's hours fall below the minimum, these employees will be treated as if they are on an approved leave of absence and will remain eligible for coverage within the plan they were in prior to the reduction in hours. Premiums must continue to be remitted to Anthem for the original amount of insurance prior to the reduction in hours.

Coverage eligibility will be based on the number of the hours working as of the end of the month prior to the date of the reduction in hours. For those benefits

based on salary or wages as of the last date worked, we will utilize the salary or wages as of the end of the month prior to the date of the reduction in hours. This accommodation will be effective March 1, 2020 through July 31, 2020. We will continue to monitor this situation and will provide additional guidance as it becomes available.

If an employee's pay is temporarily reduced during the COVID-19 crisis, how would this affect his/her life or disability benefits?

If an employer reduces an employee's pay but the employee is still eligible for coverage, the employee will remain eligible for the level of coverage in effect prior to the reduction in pay. Premiums must continue to be remitted to Anthem for the original amount of insurance in effect prior to the reduction in pay. Coverage eligibility will be based on the employee's pay as of the end of the month prior to the date of the reduction in pay. For those benefits based on salary or wages as of the last date worked, we will utilize the salary or wages as of the end of the month prior to the date of the reduction in hours. This accommodation will be effective March 1, 2020 through July 31, 2020. We will continue to monitor this situation and will provide additional guidance as it becomes available.

If an employer or owner elects to reduce or take no salary, is he/she still eligible for benefits at the rate prior to the elected reduction in salary?

Yes, premiums must continue to be remitted to Anthem for the original amount of insurance prior to the reduction in salary. Coverage eligibility will be based on the salary as of the end of the month prior to the date of the reduction. Benefits we will be based on the salary as of the end of the month prior to the date of the reduction. This accommodation will be effective March 1, 2020 through July 31, 2020. We will continue to monitor this situation and will provide additional guidance as it becomes available.

How long can I furlough an employee before I have to terminate them from my plan?

Depending upon each group policy, coverage may continue but will be subject to the terms outlined in the policy that relate to temporary layoffs and leaves of absence. Furloughs will be similarly considered.

For continuance of coverage, premium must continue to be paid, without interruption.

What happens if an employee becomes disabled or dies while out on leave or furlough? How will this work?

- Depending upon each group policy, coverage may continue but will be subject to the terms outlined in the policy that relate to temporary layoffs and leaves of absence. Furloughs, if not defined in the policy, will be treated as temporary layoffs and the corresponding policy terms will apply.
- For continuance of coverage, employee and employer premium must continue to be paid, without interruption.
- Benefits will be determined based upon the policy provisions

If an employer continues coverage for employees who are on leave/furlough but the employee doesn't return to work, when will coverage be terminated?
Coverage would terminate in accordance with the provisions of the group's insurance policy as to when insurance ends.

What happens if premiums are not paid during the grace period and furloughed employee doesn't return to work?
If premiums are not paid when due, insurance coverage will terminate for that employee as of the last day of the period for which premium was paid.

If a furloughed employee chooses to port the voluntary life coverage, will we reinstate coverage without requiring a new Eligibility Waiting Period or Evidence of Insurability?
To be eligible to port coverage, an employee's employment needs to be terminated. Regardless of whether employee ports the coverage or not, employees who are terminated and rehired within 12 months at an equivalent plan design will not require a new Eligibility Waiting Period or EOI. We will credit any amount of time the employee was previously insured under the Anthem policy toward satisfaction of policy time limits.

Will you reinstate the Short-term Disability, Long-term Disability and or Life coverage for a terminated employee without requiring a new Eligibility Waiting Period or Evidence of Insurability?

For employees who are terminated and are rehired within 12 months at an equivalent plan design we will not require a new Eligibility Waiting Period or EOI. We will credit any amount of time you were previously insured under your Anthem policy toward the satisfaction of policy time limits.

Will we be extending the layoff provision of the Continuation of Coverage benefit due to COVID-19?

Not at this time. However, we will continue to monitor the situation and provide additional guidance as it becomes available.

If changing life and disability carriers, are employees who were actively at work prior to a furlough or layoff on a prior carrier's policy, eligible for coverage at takeover while on furlough or laid off status?

Yes, as long as coverage would have continued had there not been a change of carrier. Coverage will continue based on the leave of absence provision in our policy. Payment of premium required.

If changing life and disability carriers, are employees who are below the minimum numbers of hours required on a prior carrier's policy, eligible for coverage at takeover?

If an employee's hours fall below the minimum, these employees will be treated as if they are on an approved leave of absence and will remain eligible for coverage within the plan they were in prior to the reduction in hours. Premiums must be remitted to Anthem for the original amount of insurance prior to the reduction in hours. Coverage eligibility will be based on the number of the hours worked as of the end of the month prior to the date of the reduction in hours. For those benefits based on salary or wages as of the last date worked, we will utilize the salary or wages as of the end of the month prior to the date of the reduction in hours. This accommodation will be effective March 1, 2020 through July 31, 2020. We will continue to monitor this situation and will provide additional guidance as it becomes available.

Is the insurance company allowing a longer grace period for me to pay my premiums?

Our grace period is included in the policy. However, we will adhere to mandates and/or any regulatory direction regarding grace period.

New York State insurance regulation issued a notice that temporarily changes the grace period for Individual and Small Group fully-insured health insurance policyholders who experience financial hardship due to COVID-19**.** Per the recent regulation, policyholders have until June 1, 2020 to pay their premium that was due on March 1, April 1 and May 1. This applies to commercial small group and individual subscribers except for APTC/subsidy recipients as well as full-payment Child Health Plus subscribers. Small Group fully-insured policyholders who qualify under the provisions of the regulation are required to give Empire written attestation of hardship due to COVID-19 by sending notice of financial hardship to NYGracePeriod@empireblue.com.

State-Mandated Disability Plans (e.g. CA SDI, NY DBL, NJ TDB, HI TDI)

Does Empire administer state-mandated disability plans for our customers?

We administer the NY DBL (Disability Benefits Law), NJ TDB (Temporary Disability Benefits) and HI TDI (Temporary Disability Insurance) for a number of our customers. We do not administer the CA SDI program for any customers.

Are there any changes to how we are administering these programs due to COVID-19?

Yes, New York recently enacted changes to New York DBL and PFL related to COVID-19. New York added emergency sick-leave for COVID-19 quarantine and expanded PFL and DBL for related considerations. Changes were effective immediately as of March 18, 2020 and we are administering the DBL and PFL accordingly. Additional information about these changes will be forthcoming.

Yes, New Jersey recently enacted changes to its statutory disability (TDB) and PFL law related to COVID-19. New Jersey expanded the law to allow benefits for COVID-19 quarantine and expanded PFL and TDB for related considerations. Changes were effective immediately as of March 25, 2020 and we are

administering the TDB and PFL accordingly. Additional information about these changes will be forthcoming.

As of the publication of this communication, Hawaii (TDI) has not issued any changes as to how we should be administering its programs but we continue to monitor the situation.

In California, Governor Newsom issued an Executive Order on March 13, 2020, to waive the one-week elimination period for CA SDI benefits for people who are disabled as a result of COVID-19. As mentioned above, we do not administer CA SDI for any customers.

What does the state of New York qualify as quarantine?
In accordance with the COVID-19 related changes to DBL and PFL, employees must have an order of quarantine from the state of New York, Department of Health, local board of health, or any government entity authorized to issue such an order. It's important to note that school closures and requests for non-essential personnel to remain at home may not qualify as quarantine under the program's definition.

Who is required to pay the initial New York COVID-19 sick leave benefits (up to 14 days) outlined in the COVID-19 related changes?
Employers are required to pay the initial sick leave benefits according to the number of employees they have.

Is COVID-19 infection considered a disability under these state disability programs?
Employees who have been diagnosed with the COVID-19 and are unable to work will be evaluated like any other illness under the contract, with clinical support/proof of disability required. All contract provisions apply.

Is isolation or quarantine considered a disability under these state disability plans?
We administer NY DBL, NJ TDB and HI TDI in accordance with state regulations. We are continuously monitoring to comply with any regulatory changes related to COVID-19.

Is Anthem waiving the elimination period for our Short-term Disability plans to match what California SDI is doing?
Not at this time but we continue to evaluate the situation.

Absence Management, Family Medical Leave (FMLA)

Is COVID-19 infection considered a covered leave under Anthem's FML administration plans and state leave administration plans?
Anthem administers plans in accordance with Federal and State mandates. To be covered under the Family Medical Leave Act, an employee or family member for whom they are caring would need to have official documentation that certifies that they have a serious health condition. COVID-19 could be considered a serious health condition. The following would not qualify as a serious health condition:

- A COVID-19 diagnosis without certificate by a doctor of serious health condition. An employee must have a certification by a doctor.
- An official quarantine order,
- A need to self-quarantine due to lowered immunity,
- An employee's need to care for a child due to school closure.

In regards to the employees' needs to care for a child due to school closure, the recently passed Families First Coronavirus Response Act includes the Emergency Family and Medical Leave Expansion Act. This act will expand coverage to employees who are unable to work or telework due to the need to care for a child whose school or child care provider has been closed due to the COVID-19 emergency. Employers with fewer than 500 employees must comply with the Expansion Act, although the Secretary of Labor may exclude certain health care providers and emergency responders from the definition of employee and may also exempt small businesses with fewer than 50 employees. Additional

information about the Families First Act, the Emergency Family and Medical Leave Expansion Act and the Emergency Paid Sick Leave act will be forthcoming.

At this time, employees who have a diagnosis without certification or are quarantined with no symptoms are not eligible for coverage. However, we continue to monitor potential changes in each state.

What is considered a serious health condition?
FMLA defines serious health condition as "an illness, injury, impairment, or physical or mental condition that involves: inpatient care in a hospital, hospice, or residential medical care facility; or continuing treatment by a health care provider."

What happens if an employer closes their facility and employees are unable to work?

- Employers who decide to close are responsible for decisions about wages/salary payment;
- Employees who are unable to work solely as a result of their employer's decision to close a facility would not meet the definition of "serious health condition" under the FMLA law.

What if an employee is unable to work because their child's school is closed for an extended length of time?
The recently passed Families First Coronavirus Response Act includes the Emergency Family and Medical Leave Expansion Act will expand coverage to employees who are unable to work or telework due to the need to care for a child whose school or child care provider has been closed due to COVID-19 emergency.

Employers with fewer than 500 employees must comply with the Expansion Act, although the Secretary of Labor may exclude certain health care providers and emergency responders from the definition of employee and may also exempt small businesses with fewer than 50 employees. Additional information about the Families First Act, the Emergency Family and Medical Leave Expansion Act and the Emergency Paid Sick Leave act will be forthcoming

How long can an employer keep an employee on the plan if FMLA has been exhausted and the employee is still on disability?
Anthem administers FMLA in accordance with Federal regulations associated with it. Qualification for disability benefits under the disability plan are considered independently from FMLA leaves and are governed by our Disability contract (insured) or employer plan document (self-insured). For an individual who is an active, approved insured disability claimant, their benefit will continue as long as they meet the definition of disability and other provisions under the policy until the maximum benefit period under the policy is reached.

State Paid Leave Programs

Does Anthem administer any state paid leave programs?
We administer the New York Paid Family Leave (PFL) program for many of our customers that have New York-based employees.

Is COVID-19 infection considered a covered leave under the New York PFL program?
Anthem administers New York PFL in accordance with New York PFL regulations, which permit paid leave associated with caring for a qualified family member under the law. Please refer to the New York DBL/PFL changes under the state mandated disability plan section. Additional information related to COVID-19 will be forthcoming.

Life & Accidental Death and Dismemberment Plans

Is death from COVID-19 covered by Anthem's group life plans?
Each life claim is evaluated individually in accordance to the policy. Anthem's Life coverage does not have any exclusions. Our supplemental and voluntary life plans generally only exclude suicide within two years of the employee's effective date (in Missouri, one year). A life claim for death from COVID-19 will be evaluated the same as any other infectious disease.

Is isolation or quarantine considered a disability under Anthem's life insurance waiver of premium provisions?

For fully insured groups, each case will be reviewed on its own merit, subject to the policy provisions of the disability or life policy. Employees who self-quarantine but are not diagnosed with COVID-19 will not be covered.

For self-insured groups, we will coordinate with the policyholder.

Can employees continue their group life coverage if their employer closes their facility and employees are unable to work?
Depending upon each group policy, coverage may continue but will be subject to the terms outlined in the policy that relate to temporary layoffs and leaves of absence. Furloughs will be similarly considered.

Is Accidental Death & Dismemberment coverage affected by COVID 19 related deaths?
No, coverage does not apply to a COVID-19 diagnosis.

Other Life and Disability Resources

What resources can Anthem offer to help employees and their families?

- Member Assistance Program/Resource Advisor: Groups with an Anthem Life or Disability plan have access to our Resource Advisor member assistance program. Employees have access to a licensed counselor 24/7. Resource Advisor telephone counselors can also arrange up to three visits via LiveHealth Online video counseling.
- Travel Assistance: Employees and their family members who are away from home can connect to medical, legal and other services 24/7, and can receive travel support during this pandemic. It's included with Anthem's group Life Insurance.

Supplemental Health (Accident, Critical Illness & Hospital Indemnity) Plans

For continuance of coverage, premium must continue to be paid, without interruption.

- Accident products: Typically, Accident products would not provide benefits for the diagnosis or treatment of COVID-19.

- Hospital Indemnity products: There are no policy limitations associated with hospitalization due to a diagnosis of COVID-19. All other provisions of the policy must be met.
- Critical Illness products: COVID-19 is not considered a covered condition under our Critical Illness products.

Are there any plan or policy limitations for Anthem's supplemental health plans that would impact a COVID-19 related claim?

Each claim received by Anthem will be reviewed according to policy terms and applicable laws and regulations. We continue to monitor all related regulatory developments.

- **Accident products:** Typically, Accident products would not provide benefits for the diagnosis or treatment of COVID-19. Our Accident covers injuries due to a covered accident and a virus is not an accident-related injury.
- **Hospital Indemnity products:** There are no policy limitations associated with hospitalization due to a diagnosis of COVID-19. All other provisions of the policy must be met. Our Hospital Indemnity covers admissions and related confinements due to a sickness, therefore, a hospital stay for a virus would be covered.
- **Critical Illness products:** COVID-19 is not considered a covered condition under our Critical Illness products. Our Critical Illness covers the diagnosis of 18 critical diseases and a virus is not a disease.

For employers that are required to shut down during this time, what can an employer do if an employee is not working and cannot have a premium deduction taken for their VB policies?

Premiums are required to continue coverage. Employers are required to collect and remit premiums from their employees. Non-payment of premium will result in termination of coverage.

- Can the employer pay it on their behalf if they would like? Yes.

If the employee opts to not continue to pay premium due to the lay-off, can the employee re-enroll in Supplemental Health (Accident/Critical Illness/Hospital Indemnity) later?

- Yes, the employee can re-enroll at the next annual open enrollment under the Guarantee Issue offer(s) and would not require any EOI.

Will COVID-19 testing be covered under health screening benefit of Critical Illness and Hospital Indemnity?
No, COVID-19 testing is covered by major medical plans including Anthem.

Is Empire expanding the list of covered illnesses in Critical Illness plans to cover the diagnosis of an infectious disease (like COVID-19) and pay a benefit?
COVID-19 is not included as a covered illness under Critical Illness plan. Admission and confinement would be covered for a COVID-19 related illness under a Hospital Indemnity plan.

Will Anthem offer premium forgiveness or extended grace periods?
Our grace period is included in the policy. However, we will adhere to mandates and/or any regulatory direction regarding grace period.

What is the process for portability of Anthem's supplemental plans?
Upon termination of active employment the employer as part of their administrative duties would be responsible for notifying the employee of their right to extend coverage. The employee would complete the documentation and submit to Anthem to extend coverage.

ENROLLMENT FORMS (Life, Disability and Supplemental Health)

If a group does not have the capabilities to e-sign during this time, do we accept script signatures on our forms? If the group cannot sign and scan, do we have any other options?

- If enrollment forms are sent via email from the group administrator or broker, we will process the forms with script signatures or without signatures at all. We'll also accept unsigned forms from internal sales

support and implementation teams. Forms received from members themselves via email will not be processed, regardless of signature.

- If a scanner is not available to send a completed form (with or without a signature), an email (from the group/broker) will suffice – however all elements on the form must be provided in the email (member demographic information, information corresponding to request such as term date, and group name/group number). If information pertinent to completing the request isn't provided, we'll reply to the sender to confirm details.

How will we obtain signed Evidence of Insurability (EOI) forms from employees if their employer is closed? Will we accept EOI forms without signatures?

We will continue to require the employee's signature on EOI forms. We have several acceptable options for employees to provide signed forms to us:

1. Print, sign and return signed EOI form to us via U.S. Postal service
2. Print, sign, scan and email signed EOI form to us
3. Use the Fill and Sign (Esign) option on our fillable forms. Follow the instructions when prompted and email signed form to us
4. Print, sign, take a picture of the signed EOI forms using your mobile phone, and email photo of signed form to us.

We cannot accept a typed signature, nor can we accept an EOI form without a signature.

How will we handle an Evidence of Insurability application that would normally require a paramedical exam but the paramedical vendors are unable to perform exams at this time?

We will pend the application until the paramedical exam can be safely conducted. We will continue to monitor the situation and provide additional guidance as it becomes available.

What resources can Anthem offer to help employees and their families?

- Member Assistance Program/Resource Advisor: Groups with an Anthem Life or Disability plan have access to our Resource Advisor member assistance program. Employees have access to a licensed counselor 24/7. Resource Advisor telephone counselors can also arrange up to three visits via LiveHealth Online video counseling.

- Travel Assistance: Employees and their family members who are away from home can connect to medical, legal and other services 24/7, and can receive travel support during this pandemic. It's included with Anthem's group Life Insurance.

Dental Questions

Will Empire allow an extension to dependents who are aging out past 26 for dental coverage; and 18 for orthodontics treatment?
If the Large Group employer has a plan that results in dependents aging out at the end of the month and not end of the calendar year, Empire will allow an off-cycle benefit change and the entire group will be moved to the end of the calendar year. The Summary of Benefits Coverage 60-day notice requirement does not apply unless other benefit changes are made. For Small Group employers, the aging out date will remain the end of month.

Is Empire closing its dental customer service offices?
Our offices remain open. To protect our internal associates, many of our customer service representatives have successfully transitioned to work at home during the COVID-19 crisis. Our service standards remain unchanged and we remain committed to excellence in serving the needs of our members, groups, brokers, providers, internal associates and all constituents. Dental customer service is available from 7 a.m. to 7 p.m. CT.

Is Empire setting up any special member service hotlines?
We are using our existing phone numbers because members are used to calling them. We have managers and subject matter experts readily available to respond to questions. Staff also have COVID-19 message prompts on the desktops.

Are there resources groups can share with members on maintaining their dental health during the COVID-19 pandemic?

As part of our Time Well Spent® online employer health and wellness toolkit, Empire provides a turnkey promotional campaign and resources for dental health.

We designed the kit to help customers create a healthy, productive workplace and support the overall well-being of their workforce. Check out all the resources available at timewellspent.empireblue.com, which are especially helpful for groups and their members at this time in promoting good oral health practices as many provider offices are closed due to COVID.

In addition, members should be encouraged to talk with their dental office for guidance, and members can also access external resources such as the ADA's Mouth Healthy dedicated COVID-19 web page.

How are Empire and dental providers handling the temporary closure of dental offices?

The health and safety of our members and providers is our top priority. As of March 16, 2020, many dental clinics and offices are following the advice of the American Dental Association and local health authorities to limit routine dental care for the next three weeks. This is to help redirect emergency dental care, such as toothaches, away from hospital emergency rooms, as well as protect the health of patients and dentists alike.

What if members have a dental emergency?

Should members have a dental emergency, they should contact their dentist and explain their situation.

- Their dentist will advise them of the appropriate care and place of treatment.
- If a dental office visit is required, they may be asked to practice "social distancing," such as remaining in their vehicle while waiting for their appointment to begin to limit the potential spread of the virus.
- If they are unable to obtain care, members should call the number on the back of your ID Card for assistance or access www.empireblue.com and select "Contact Us."

What is the definition of non-essential or non-emergency care?

Non-essential services include but are not limited to new patient and continuing patient examinations, route visits and cleanings, periodontal maintenance and

root planning, non-urgent restorative care such as fillings and endodontic treatment such as root canals.

What if I have a dental treatment already in progress? Will I have to wait?
For dental treatment already in progress, members should contact their dentist directly and inquire about next steps. Their dentist will advise them of appropriate care. If they have a dental emergency and their provider is not available, they should contact us at the number on the back of their ID card for assistance or access www.empireblue.com and select "Contact Us."

How is Empire handling transition in care for Dental – for example if I had a treatment in progress and was unable to complete final treatment because my dentist office is now closed?
Normal transition of care rules would allow for treatment in progress to be paid by the carrier where treatment was initiated. Typically, plans have an extension of benefits provision of up to 60 days to address this issue and you should contact your prior carrier for assistance.

If an extension of benefits provision is not in place with the prior carrier, Empire Dental does provide transition of care and coverage according to the contract and benefits.

Is Empire adjusting Dental frequency limitations?
Our standard benefits are most commonly set up with annual or multi-year frequencies, therefore we are not making changes or adjustments to benefits/frequency limitations at this time.

If members receive an EOB that states Empire needs more information to process a claim and their dental office is closed, is there a time limit on their provider returning information?
We will accept the information and process the claim whenever the provider is able to submit information.

Will Empire honor dental care through teledentistry?
Yes. Many dental providers already use teledentistry for different types of dental care, including routine preventive services, assessing restorative care like fillings and crowns, and it is especially effective for emergency care and consultations.

- Teledentistry, including online and mobile-phone enabled care, are eligible for coverage.
- Mobile options such as employer-sponsored near-site and onsite visits are also eligible.
- For coverage to apply, services must be covered under members' dental plan. Members should call the number on the back of their ID card for assistance or access www.empireblue.com and select "Contact Us."

How is Empire using teledentistry to help members in light of COVID-19?
While we encourage members to contact their primary care dentists for all dental care needs, we are pleased to announce beginning May 1, 2020, the TheTeleDentists® will offer nationwide network access to board-licensed dentists for emergency dental care. There are no out-of-pocket costs through Sept. 30, 2020, and members' emergency dental care can be addressed without a visit to an emergency room or urgent care center. We are also pleased to announce that we have partnered with leading online retailers for our Ortho@Home program – offering at-home clear orthodontic aligners. By using laptops, tablets or smart phones, dental care is now available around the clock, every day of the year, through board-licensed dentists.

Will Empire honor dental care through teledentistry after the COVID-19 pandemic?
Yes. Empire is committed to teledentistry and will continue to cover teledentistry services the same as if those services were provided in a dentist office. For coverage to apply, services will be required to be covered under member benefit plans. Cost sharing will apply based on how benefit plans categorize services.

What support does your organization offer their contracted/participating dental providers at this time? Specifically, what measures are being taken to ensure your organization maintains a robust and healthy network of providers? Are

there any contract provisions, features, relief programs or other services available to support small dental offices/practices?

We continue to provide dedicated support to dental providers, and our offices remain open. To protect our internal associates, many of our network representatives have successfully transitioned to work at home during the COVID-19 crisis. Our service standards remain unchanged and we remain committed to excellence in serving the needs of our providers. We are staffed to continue being responsive to their inquiries and well as continuing prompt claims processing to avoid causing any additional disruption to their practices.

- At this time, we have not experienced a loss of network providers due to the pandemic. In fact, our network continues to grow, and through Empire groups have access to the largest nationwide dental network available today with more than 133,000 unique dentists.
- We are set up to accept and process teledentistry claims in the same manner that providers submit claims today. Each day we are monitoring state orders and bulletins related to teledentistry. We are processing all claims promptly, including teledentistry claims, to ensure that provider reimbursement is received quickly. We have advised providers they can address questions related to specific members' teledentistry claims through the customer service number on the back of members' ID Cards, or for general teledentistry questions, they can contact Network Services at 1-866-947-9398.
- Additionally, as a resource for dental practices, during the week of April 20, the federal government is voting to approve relief funding through the Paycheck Protection Program and Health Care Enhancement Act that allocates roughly $484 billion to replenish small business loan programs instituted in the previously passed CARES act.

Can members continue dental coverage if their employer closes their facility, reduces hours or furloughs employees and they are unable to work or my hours are reduced?

We are relaxing our policy through Sept. 30, 2020, to allow for coverage in this scenario if part or all of an employer's workforce is laid off or not working in response to the COVID-19 crisis. Please check with their employer group for additional details. For continuance of coverage, premium must continue to be paid, without interruption.

For dental, how is Empire handling issues related to underwriting guidelines and changes in workforce?
Empire is handling underwriting and change in workforce issues for dental to be consistent with the approach we are taking for Medical.

Is Empire reimbursing dentists in its networks for personal protective equipment costs?
We recognize the additional cost burden dental providers are facing today because of a reduced supply and increased prices for personal protective equipment as they open their offices to patients for routine care and follow strict protective guidelines. As a result, we are reimbursing dentists in our Dental Prime and Dental Complete contracted networks for PPE costs by implementing a $10 temporary payment of PPE per visit starting on June 15 for three months. We are aligning with the ADA's recommendation for dentists to submit the PPE cost to us using CDT code D1999. Payment will occur seamlessly as with other claims submissions. Network providers will be notified of our PPE reimbursement and asked not to seek additional copays from members at time of dental visits.

Vision Questions

What is the status of vision clinics resuming routine treatment?
Many offices that previously were closed due to restrictions in place from local health authorities and following advice from the Centers for Disease Control have re-opened or are re-opening for routine vision care.
We recommend members contact their vision providers to verify if offices are open, hours of operations, new processes for receiving care and appointment timelines because providers in certain locations may be dealing with a backlog of

patients, limited hours or difficulty in obtaining personal protective equipment to treat patients.
If members are unable to reach their office or need additional assistance, they should call the number on the back of their ID card.

Will Empire allow an extension to dependents who are aging out past 26 for vision coverage?

If the Large Group employer has a plan that results in dependents aging out at the end of the month and not end of the calendar year, Empire will allow an off-cycle benefit change and the entire group will be moved to the end of the calendar year. The Summary of Benefits Coverage 60-day notice requirement does not apply unless other benefit changes are made. For Small Group employers, the aging out date will remain the end of month.

Is Empire setting up any special member service hotlines?

We are using our existing phone numbers because members are used to calling them. We have managers and subject matter experts readily available to respond to questions. Staff also have COVID-19 message prompts on the desktops.

Are there resources groups can share with members on maintaining their vision health during the COVID-19 pandemic?

As part of our Time Well Spent® online employer health and wellness toolkit, Empire provides a turnkey promotional campaign and resources for vision health. We designed the kit to help clients create a healthy, productive workplace and support the overall well-being of their workforce. Check out all the resources available at timewellspent.empireblue.com, which are especially helpful for groups and their members at this time in promoting good vision health practices as many provider offices are closed due to COVID.
In addition, members should be encouraged to talk with their vision office for guidance, and members can also access external resources such as the AAO.org dedicated COVID-19 web page.

What if members have ordered eyewear? Will they have to wait to pick them up?

For eyeglass or contact lens orders in progress, members should contact their provider's office for next steps. Their provider will advise you of their office policy whether amending store hours or closing.

What if members are unable to visit a provider and they experience an eyewear emergency?

If members have lost, broken or damaged their eyewear, they should contact customer services so they can discuss benefit options with them. Alternatively, if members are unable to leave their home or locate an open provider and they do not have a valid prescription, they can also contact customer service. They may be eligible to receive an emergency pair of replacement Adlens Adjustable Glasses at no cost, subject to availability. These temporary, emergency glasses can be adjusted to switch focus for reading, computer and distance.

Is Empire adjusting Vision frequency limitations?

We are not making changes to our benefits/frequency limitations at this time. Members can continue to use their vision benefits online through our Blue View Vision network, which includes 1-800Contacts.com, Glasses.com, Ray-Ban.com, LensCrafters.com, TargetOptical.com and Contactsdirect.com as in-network providers. Member benefits are applied on these sites during checkout and glasses and/or contacts are mailed directly to a member's home.

We have also been working with 1800Contacts.com, which is partnering with doctors to create a solution to renew your prescription from home if you are seeing well with your current or recently expired prescription. Visit 1800Contacts.com and click "learn more about ExpressExam" for more information.

For vision, how is Empire handling issues related to underwriting guidelines and changes in workforce?

Empire is handling underwriting and change in workforce issues for Vision to be consistent with the approach we are taking for Medical.

Can members continue vision coverage if their employer closes their facility, reduces hours or furloughs employees and they are unable to work or their hours are reduced?

We are relaxing our policy through July 31, 2020, to allow for coverage in this scenario if part or all of an employer's workforce is laid off or not working in response to the COVID-19 crisis. Members should check with their employer for additional details. For continuance of coverage, premium must continue to be paid, without interruption.

How can members prepare for going to the eye doctor?

Here are a few reminders for members with an eye appointment:

- If members or their family members are not feeling well, they should stay at home. They should contact their provider to cancel and reschedule your appointment.
- If members have any questions about an upcoming appointment, they should contact their providers.
- Many providers are asking additional screening questions related to COVID-19 such as if members have traveled overseas or if they have any respiratory symptoms. Providers may also take members' temperature.
- As a reminder, health professionals including dentists and vision providers follow infection control procedures in their practice as required by state law and as currently directed by the Centers for Disease Control and Prevention.

What is the role of the vision practitioner in maintaining a safe environment for staff and patients?

The American Academy of Ophthalmology, also known as the AAO, has issued a detailed guide for optical providers, which will help members understand the steps and precautions vision professionals are being asked to take to ensure their health and safety. Offices are being asked to follow the same stringent cleaning and disinfection strategies used during flu season.

Providers are receiving recommendations for ways to decrease risk through no-touch receptacles reducing potential exposure in small or crowded waiting rooms by offering patients the option to wait in their car or somewhere else in close

proximity and then receiving a phone call or text message when it is their turn for treatment, as well as extra care when assisting patients who may have a cough or other respiratory symptoms. According to the United States Department of Health and Human Services, telehealth options for services can apply whether or not patients have COVID-19 symptoms.

How can care be ensured in a safe setting?
While we believe strongly in the quality of care provided by the providers in our network, members should let us know if they experience anything in a provider's office that causes concern. In such a case, members can let us know immediately by calling the phone number on their ID card.

Federal Legislation and Guidance Questions

How does the CARES Act apply to fully-insured and self-funded plans?
The CARES Act:
Requires coverage without cost sharing of COVID-19 diagnostic tests that are in addition to the test required by the Families First Act.

- Tests approved by the FDA, a state, or other methods approved by the Secretary of Health and Human Services must be covered. In addition, a test that is or will be under an active emergency use authorization request to the Food and Drug Administration must also be covered.
- Plans must cover testing at the in-network provider negotiated price or, if the plan does not have a negotiated price with the provider, the cash price as listed by the provider on a public Internet website.

Requires coverage without cost sharing of any qualifying preventive service for COVID-19.

- Coverage required 15 business days after a favorable recommendation from the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- A qualifying preventive service includes an item, service, or immunization intended to prevent or mitigate COVID-19.

Amends the Health Savings Account, or HSA rules.

- A high deductible health plan with an HSA beginning on or before December 31, 2021, can cover telehealth services and other remote care services prior to an HSA-eligible individual reaching the deductible.
- This change only extends to 2020 and 2021 plan years.

Allows over-the-counter medicines and drugs to be paid for with HSA, health flexible spending accounts, FSA, FSA, and health reimbursement accounts (HRA).

- Additionally, menstrual care products are treated as qualified medical expenses and can be paid for with HSA, FSA, and HRA dollars.
- These changes are effective for purchases beginning in 2020 and apply indefinitely.

How does the recent federal legislation impact health care?

To find information about provider funding, go here: https://share.antheminc.com/teams/PublicPolicy/Resource/Anthem_Memo_Provider_Funding_Federal_Phase-III_COVID-19_Stimulus_Legislation.pdf

To find information about hospital funding, go here: https://share.antheminc.com/teams/PublicPolicy/Resource/Anthem_Memo_Hospital_Funding_Federal_Phase-III_COVID-19_Stimulus_Legislation.pdf

To find information about employer benefits, go here: https://share.antheminc.com/teams/PublicPolicy/Resource/Anthem_Brief_Financial-Relief-for-Employers-in-Federal-PhaseIII-COVID-19-Stimulus-Law.pdf

For an overall summary, go here: https://share.antheminc.com/teams/PublicPolicy/Resource/Anthem_Summary_COVID-19_Federal_Legislation.pdf

Frequently Asked Questions related to federal guidance entitled "Notification of relief; extension of timeframes" issued May 4, 2020 at 85 FR 26351 ("Federal Guidance").

How is Empire addressing Federal Guidance that pushes back due dates for enrollment, claims, grievances and appeals, and independent external review?

Under the guidance, ERISA group health and disability plans must push back certain due dates effective March 1 until 60 days after the end of the declaration of the National Emergency or "Outbreak Period," whichever is later.

The following due dates are pushed back:

- The 30-day period (or 60-day period, if applicable) to request special enrollment
- The 60-day election period for COBRA continuation coverage
- The date for making COBRA premium payments
- The date for individuals to notify the plan of a qualifying event or determination of disability
- The date within which individuals may file a benefit claim under the plan's claims procedure
- The date within which claimants may file an appeal of an adverse benefit determination under the plan's claims procedure
- The date within which claimants may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination
- The date within which a claimant may file information to perfect a request for external review upon a finding that the request was not complete.

Empire will enroll participants and suspend timeframes for claims and appeals in a manner consistent with the guidance for group health and disability plans effective March 1, 2020. Empire will forward independent external reviews requests consistent with plan timeframes.

Please note, the "Outbreak Period" is a definition that provides additional relief for a particular location beyond that which is generally applicable under the declaration of the National Emergency.

The "Outbreak Period" is defined as the period beginning March 1, 2020 and ending 60 days after the date on which the federal government declares the COVID-19 national emergency has ended with respect to a particular location (which has yet to be determined) and may be announced by the Department of Labor and Treasury in a future notice. The Outbreak Period may not be longer than one year. As an Outbreak Period has not been announced for any particular location, Empire recommends employers monitor updates by visiting the Department of Labor's website. If an Outbreak Period is announced, Empire will also update these FAQs to provide additional guidance.

Do Federal Guidance suspensions apply to dental or vision coverage?
Timeframes pertaining to COBRA extensions and claims/appeals extensions apply to dental and vision coverage. Extensions related to special enrollment and independent external review do not apply to dental or vision coverage.

Do suspensions apply to non-governmental plans or issuers?
No. HHS issued subsequent guidance that makes clear these suspensions are merely suggestions for non-governmental plans (i.e. church plans) and health insurance issuers.

What does the Federal Guidance mean for employers?
Employers should ensure that eligibility determinations take into account the relief under the guidance. Employers should push back due dates for accepting special enrollment applications. Employers should also push back due dates for COBRA elections and due dates to pay COBRA premiums.

Anthem does not make eligibility determinations on behalf of the group. Because of this, groups should consult their legal counsel and benefits advisors on their responsibilities regarding eligibility determinations, including determinations related to COBRA.

Even though due dates are pushed back, Anthem does not recommend sending enrollment files to Anthem unless the member is enrolled and paid to date. If a member has enrolled but has not paid, Anthem recommends suspending or terminating coverage for that member pending payment of premium. If premium is not paid for all enrollees, coverage for the entire group may be cancelled.

Most groups do not utilize Anthem for COBRA administration. However, if an employer uses Anthem's vendor WageWorks for COBRA administration, WageWorks will send eligibility information to Anthem for members who are enrolled and paid to date. If an enrollee has not paid, WageWorks will not communicate to Anthem that the member is covered under COBRA. However, Anthem can assist with retroactive enrollments once the member is paid to date.

What does the Federal Guidance mean for current employees?
The relief provides additional time to take advantage of special enrollment rights. If employees lose eligibility for other coverage or have a triggering event such as marriage, birth, adoption, placement for adoption, placement in foster care, or child support that occurs during the National Emergency or Outbreak Period, the relief provides additional time to enroll in an employer's group health plan.

What does the Federal Guidance mean for employees who have lost their job or have had hours reduced and they no longer qualify for full-time employee coverage?
The relief provides additional time to enroll in COBRA continuation coverage. Under COBRA, employees may elect to stay on the same coverage or move to another option under the employer's plan. However, the employer is not required to pay for employee coverage so the employee monthly payment may increase compared to what the employee was used to paying previously.

What does Federal Guidance mean for claims?
The relief provides additional time to submit claims for processing and payment.

What does Federal Guidance mean for appeals and independent external review?

Plans typically require at least 180 days to file an appeal of a denied claim. The relief provides additional time to submit appeals. It also includes additional time to request an independent third-party decision if the plan is subject to the federal process for independent external review.

Is Anthem updating member communications due to the Federal Guidance?
Although timeframes have been suspended, timeframes have not changed under federal guidance. Anthem does not anticipate changing current communications that include due dates but Anthem will provide to group health plans and cascade to members notice that timeframes have been suspended.

What is the impact of the Federal Guidance to COBRA payment due dates?
Any days within the National Emergency or Outbreak Period are disregarded when calculating COBRA payment due dates. We recommend referring to the guidance for more specific examples.

Are employers required to pay COBRA enrollees premiums during the National Emergency or Outbreak Period due to the Federal Guidance?
No. The guidance does not require employers to pay COBRA enrollee's premiums.

What happens if no payment or only partial payment is made for dates during the National Emergency or Outbreak Period due to Federal Guidance?
If no payment or only partial payment is made, the group bill will show a balance due, carry forward amount, and group coverage will be in effect until the billing threshold is reached and will remain in effect through the last paid to date. Because of this, Anthem recommends sending eligibility files, and maintaining eligibility, for only those members who are eligible and paid to date. Otherwise, coverage for the entire group may be cancelled.

Will Empire pend or reject claims if payment is not made?
Empire will pend and reject claims consistent with existing processes. For example, if a grace period applies claims may be pended. However, claims may be rejected if the member's eligibility and payment information is not up to date.

Are Empire's customer service representatives equipped to address questions from group customers regarding Federal Guidance? Empire's call centers are equipped to answer questions related to the suspension of timeframes and can provide members information about eligibility, payment, and claims. Members should contact Empire using the number on their ID card if they have any questions.

A member received a notice that a claim will be denied if the member does not submit additional information within a certain timeframe. Is this correct?
The timeframe is correct, but Anthem will disregard days that occur during the National Emergency or Outbreak Period. Anthem will count days against the timeframe provided under the notice once the National Emergency or Outbreak Period ends. If the notice includes a due date, this due date can be used to determine how much additional time is available once the National Emergency or Outbreak Period ends.

A member received a notice that COBRA coverage will be cancelled if payment is not made within a certain timeframe. Is this correct?
The timeframe is correct, but Anthem will disregard days that occur during the National Emergency or Outbreak Period. Anthem will count days against the timeframe provided under the notice once the National Emergency or Outbreak Period ends. If the notice includes a due date, this due date can be used to determine how much additional time is available once the National Emergency or Outbreak Period ends.

How much additional time will members have to submit eligibility, COBRA payment, or claims information?
It depends. Timeframes are suspended until 60 days after the end of the National Emergency or Outbreak Period. After this 60-day period, Anthem will start counting days against timeframes. Because each situation may be different, Anthem recommends submitting information as soon as possible. Please see specific examples under **Federal Guidance** for more information.

If claims are rejected because a member's eligibility or payment information is not current, can claims be reprocessed if updated eligibility or payment information is provided?
Yes. Anthem can reprocess claims if updated payment or eligibility information is provided. If claims need to be reprocessed based upon updated eligibility and/or payment information, members should contact Anthem using the number on their ID card.

Will Anthem provide notice that the National Emergency or Outbreak Period has ended?
Anthem will cascade notice to group health disability plans that the National Emergency or Outbreak Period has ended. However, we recommend monitoring the Department of Labor's website for additional updates.

State Mandate Questions

How are Empire health plans addressing public health emergency mandates?
As always, Empire health plans will follow mandates from public health emergency mandates, which generally apply to fully-insured, Medicaid and Medicare plans.

New York

How do the mandates in the state of New York impact members and plan sponsors?
The New York Department of Financial Services (DFS) has issued a circular letter dated March 20, asking all insurers to suspend certain utilization management review and notification requirements to free up staff for clinical support. Effective March 20, Empire has implemented the following responses for Individual, employer-based fully-insured and self-insured (ASO)*, Medicare** and Medicaid plans.

Will Empire be removing prior authorization requirements for scheduled surgeries or admissions at hospitals?
Empire is committed to working with and supporting hospitals. As of March 20, Empire is removing prior authorization requirements for scheduled surgeries or admissions at hospitals for the next 90 days to allow hospitals to utilize needed staff in clinical roles. Hospitals should continue admission notification to Empire in an effort to verify eligibility and benefits for all members prior to rendering services and to assist with ensuring timely payments. Empire may review any applicable cases retrospectively upon the resumption of retrospective review. Prior authorizations are suspended for 90 days, from March 20 – June 20, 2020.

Will Empire be suspending concurrent review of inpatient hospital services?
Empire is suspending concurrent review requirements for 90 days effective March 20. Hospitals should continue admission notification to Empire in an effort to verify eligibility and benefits for all members prior to rendering services and to assist with ensuring timely payments. This will help reduce the amount of communication with Empire to allow hospitals to focus on patient care. Empire shall review any applicable cases retrospectively upon the resumption of retrospective review.

How will retrospective reviews for inpatient hospital services and emergency services be handled?
Empire is suspending retrospective reviews for inpatient hospital services and emergency services provided at in-network hospitals for 90 days. The effect of this change is these claims will be paid without being reviewed for medical necessity for 90 days effective March 20. The Circular Letter explains that hospitals should not enforce any contractual limitations regarding the permissibility of retrospective review or overpayment recovery.

Will hospitals be required to obtain prior authorization for home health care and inpatient rehabilitation services following an inpatient hospital stay?
In an effort to allow hospitals to increase inpatient capacity by quickly discharging patients to subacute or home settings, Empire is suspending for 90 days prior authorization requirements for home health care services and inpatient rehabilitation stays (including inpatient rehabilitation services for mental health

or substance use disorder treatment) following an inpatient hospital admission. Home health care services may be reviewed concurrently and retrospectively. This applies to concurrent and retrospective reviews for home health care services. This will allow members to be discharged more quickly and into services that will aid in their recovery from inpatient services. Hospitals must make every effort to transfer patients to in-network rehabilitation facilities. Empire shall review any applicable cases retrospectively upon the resumption of retrospective review.

How are notification requirements for emergency hospital admissions impacted?
Empire is suspending requests for medical records as part of the notification for emergency hospital admissions for 90. Hospitals should continue admission notification to Empire in an effort to verify eligibility and benefits for all members prior to rendering services and to assist with ensuring timely payments.

Will Empire be suspending its hospital payment and overpayment recovery audits?
Empire is suspending for 90 days non-essential audits of hospital payments. This will allow hospitals to focus on patient care during this crisis. The Circular letter indicates that hospitals should toll contractual time limits on audits and overpayment recoveries while these audits are suspended.

* Because ASO plans are not insured, these customers have the option to opt out of the following provisions if they so choose.

** For Medicare plans, please note:

- A shorter timeframe or changes in action may be necessary where required by federal law.
- Medicare reserves the right to perform post-payment reviews for all services.
- Medicare appeals timeframes are dictated by CMS.
- Audits/Recovery: Medicare is exempt from that statement.

Why is Empire expanding the UM suspension to include outpatient procedures and increase limits on retrospective review?

The DFS has issued a supplement guidance that extends the suspension of utilization review to include outpatient procedures and increased limitations on retrospective review within the 90 day period that began 3/20.

Why did the New York Department of Financial Services (DFS) update the original circular letter?
Please visit the DFS site for a summary of the reasoning.

Who is impacted by the utilization review suspension supplement guidance?
Individual and employer-based fully-insured plans (Small group and Large group).

Safety and Preparedness Questions

What has Empire been doing to prepare?
Empire is committed to help provide increased access to care, while eliminating costs and help alleviate the added stress on individuals, families and the nation's healthcare system.

These actions are intended to support the protective measures taken across the country to help prevent the spread of COVID-19 and are central to the commitment of Empire's affiliated health plans to remove barriers for their members and support communities through this unprecedented time.

Empire is committed to help our members gain timely access to care and services in a way that places the least burden on the healthcare system. Our actions should reduce barriers to seeing a doctor, getting tested and maintaining adherence to medications for long-term health issues.

Empire is waiving:

- cost-sharing for the treatment of COVID-19 from April 1 through May 31, 2020 for members of its fully-insured employer, Individual, Medicare Advantage and Medicaid plans. We encourage our self-funded customers to participate, although these plans will have an opportunity to opt out.
- cost-sharing for COVID-19 diagnostic and serology tests for members of our employer-sponsored, individual, Medicare and Medicaid plans.

- cost-sharing for visits to get the COVID-19 diagnostic test, regardless of whether test is administered, beginning March 18 for members of our employer-sponsored, individual, Medicare and Medicaid plans.
- cost-sharing for COVID-19 screening related tests (e.g., influenza tests, blood tests, etc.) performed during a visit that result in an order for, or administration of, diagnostic testing for COVID-19 will also be covered with no cost sharing for members.
- cost-sharing for telehealth visits, including visits for behavioral health, for our fully-insured employer, individual, and Medicare Advantage plans, and where permissible, Medicaid plans for 90 days, beginning March 17. We encourage our self-funded customers to participate, and these plans will have an opportunity to opt in.
- cost-sharing for FDA-approved medications or vaccines when they become available.

The cost-sharing waiver includes copays, coinsurance and deductibles.

For additional services, members will pay any cost shares their plan requires, unless otherwise determined by state law or regulation. Members can call the number on the back of their identification card to confirm coverage. Providers should continue to verify eligibility and benefits for all members prior to rendering services.

Telehealth (video and audio):

For 90 days effective March 17, 2020, Empire will waive member cost shares for telehealth visits, including visits for mental health or substance use disorders, for our fully-insured employer plans, Individual plans, Medicare plans and Medicaid plans, where permissible. Cost sharing will be waived for members using Empire's authorized telemedicine service, LiveHealth Online, as well as care received from other providers delivering virtual care through internet video and audio services. Self-insured plan sponsors may opt out of this program.

Note: Telehealth does not include the use of facsimile, telephone-only, or email.

Telephonic-only care

For 90 days effective March 19, 2020, Empire will cover telephonic-only visits with in-network providers. Out-of-network coverage will be provided where required. This includes visits for behavioral health, for our fully insured employer plans, individual plans, Medicare plans and Medicaid plans, where permissible. Cost shares will be waived for in-network providers only.

Prior authorizations

Prior authorizations are suspended for 90 days, from March 20 - June 20, 2020.

Prescription Coverage

Empire affiliated health plans are also providing coverage for members to have an extra 30-day supply of medication on hand. And, we are encouraging that when member plans allow that they switch from 30-day home delivery to 90-day home delivery.

For other covered services, members will pay cost shares their plan requires, unless otherwise determined by state law or regulation. Members can call the number on the back of their identification card to confirm coverage. Providers should continue to verify eligibility and benefits for all members prior to rendering services.

How is Empire employing strategies to protect employees and reduce the likelihood of them contracting COVID-19?

The health and safety of Empire associates and the various stakeholders we serve is a top priority for our business every day. Empire is monitoring developments related to COVID-19 in accordance with the Centers for Disease Control and Prevention.

We are taking steps to ensure our operations remain uninterrupted, while ensuring the health and safety of our associates. We are employing social distancing strategies, using teleconference and video conferencing capabilities whenever possible and encouraging work at home where appropriate. Empire sends out regular communications to its associates and maintains a resource page on our associate-facing intranet site that provides resources including the recommendations from the CDC to reduce the likelihood of contracting COVID-19. Empire also maintains a dedicated internal mailbox for questions from our Empire associates about COVID-19.

How is Empire communicating with consumers, customers, employees and vendors to deliver important news and take in questions?
The health and safety of Empire associates and the various stakeholders we serve is a top priority for our business every day. Empire communicates to our members, employers, and producers on our website at www.empireblue.com. On this blog there are both general information about COVID-19 and prevention and treatment and information about how Empire members' coverage covers testing and treatment for COVID-19.

Additional resources, like the Sydney Care mobile app and LiveHealth Online, are listed as well. Empire associates have dedicated email addresses for submitting both internal questions as well as external questions from our members and producers and providers.

How is Empire monitoring COVID-19?
Empire's comprehensive enterprise wide business continuity program includes recovery strategies for critical processes and supporting resources, automated 24/7 situational awareness monitoring for our footprint and critical support points, and Empire's Virtual Command Center for Emergency Management command, control and communication. In addition, Empire has established a team of experts to monitor, assess and help facilitate timely mitigation and response where it has influence as appropriate for the evolving novel coronavirus threat.

Does Empire have a business continuity plan in the event of a pandemic?

- Empire maintains a comprehensive enterprise wide business continuity program that aligns business requirements of our operating units and related support areas to help us meet our commitments following an "unplanned event."
- This plan includes strategies for a "People Unavailable" event, including a pandemic, to help us continue critical business processes to meet our customer commitments.

- Response to and mitigation of such an event can include leveraging our broad geographic footprint, work from home capability, increased personal hygiene and additional building hygiene measures and frequency, travel restrictions, isolation of personnel, and limiting access to and travel between our facilities.
- All of this is documented in established policies and procedures to support crisis response measures, such as during a pandemic threat.

Privacy Questions

Can Empire provide my company with information regarding COVID-19 cases within our member population?

Applicable law limits Empire's ability to share an individual's protected health information with an employer absent an authorization or certain extenuating circumstances. As a result, Empire is limited by law in its ability to disclose individual's protected health information to an employer.

HIPAA permits limited disclosure of protected health information to group health plan representatives if:

- The requestor is a group health plan representative and,
- The purpose of the request is related to the operations of the health plan.

Under the current circumstances, information regarding COVID diagnoses is unlikely to relate to the health plan's operations. Nevertheless, when receiving such requests, we will inquire about the nature of the request and the requestor's role to determine what protected health information, if any can be disclosed.

Most importantly, Empire may not have records indicating any affirmative medical diagnosis. We recommend that employer groups concerned about the virus work with relevant regional and national public health authorities to remain apprised of any developments.

What information can Empire provide to a self-insured group looking to potentially expand its benefit coverage amid the COVID-19 response?

Empire can provide self-insured groups with information, including protected health information where necessary, for the plan's payment and health care operations purposes.

For example, Empire may provide an authorized health plan representative with information regarding current claims experience so that the plan can evaluate the possible expansion of benefits from a scoping, cost and coverage standpoint. However, it is important to distinguish between an authorized group health plan representative acting on behalf of and in furtherance of the ASO group health plan and the employer as sponsor of a group health plan. Empire cannot make such disclosures of PHI to an employer for the employer's purposes, such as a general interest in determining if their associate has been diagnosed/treated for COVID-19.

What are the limited circumstances in which Empire may provide an ASO group health plan representative with PHI or a limited data set related to COVID-19?
If a self-insured group health plan provides assurances that the data will be provided to an authorized group health plan representative and will only use the data for a permissible purpose, Empire can consider releasing the data.

Empire would consider providing PHI or a limited data set under the following circumstances:

- For payment purposes, including cost and/or risk management (possible consideration of stop-loss claims)
- To evaluate the financial impact potential changes in a plan of benefit, such as to cover more COVID-19 related costs
- To coordinate care and/or support care management activities that are run or supported by the self-insured group health plan or a third party other than Empire acting on behalf of the self insured group health plan

Non-permitted employment purposes include:

- Data to identify where office closure is prudent
- To confirm if an employee suspected of having COVID-19 was diagnosed
- To obtain information to support a short-term disability claim without an authorization from the individual

- To evaluate whether individuals involved in a planned workforce reduction are undergoing COVID-19 related treatment

In all cases where a request appears permissible, we should be asking what information is absolutely necessary. In some cases, identifiable information may be needed, but not in all cases. Please consult with the Privacy Office or Legal to ensure that appropriate documentation is obtained prior to releasing data to a self-insured group health plan under these circumstances.

A group has requested de-identified data related to COVID-19, can the data be provided?
Under the current circumstances, de-identified data may still provide sufficient information when coupled with information from the group health plan to identify the individuals. This is especially true as the number of cases of COVID-19 overall are still limited.

At this time, no datasets with less than 50 self-insured group health plan members should be released to a self-insured group health plan unless the request has been screened by Privacy and Legal. With respect to fully-insured group health plans, there generally is not a function or purpose for which the fully insured group would have permissible purpose for COVID-19 related data as Empire acts as the insurer and performs the relevant health care operations and payment purposes.

If a fully insured group health plan falls into an extraordinary exception, such as its benefits plan includes carved out services like medical carved out from hospital claims, consult with the Privacy Office or Legal to evaluate the request.

There have been several announcements made by the Health and Human Services Office for Civil Rights easing some HIPAA Privacy Rules recently. Does this mean that we do not need to follow certain HIPAA requirements given the current epidemic?
No. HIPAA still applies to health plans and we should be following our existing policies and procedures. Limited enforcement discretion has been offered by HHS

OCR, but the discretion offered thus far does not directly apply to an insurer or group health plan. Below is a summary of recent activity:

- Telehealth: On March 17, 2020, HHS issued a notice of enforcement discretion to allow health care providers to serve patients wherever they are. This announcement was followed by additional telehealth guidance on March 20, 2020.
- Hospitals: On March 19, 2020, HHS issued a limited waiver of sanctions against covered hospitals for failure to obtain patient consent to speak to family members, to opt out of listing in the patient directory, and the patient's right to request privacy restrictions and confidential communications.
- Public Health and Health Oversight Activities Involving Business Associates: On April 2, 2020, HHS issued a notice of enforcement discretion to allow covered entities and their business associates to make good faith use or disclosure for certain permissible public health and/or health oversight activities during this nationwide public health emergency subject to certain notice requirements.

This does not materially impact how we operate, so please continue to coordinate with the Privacy Office for any health oversight or public health disclosures.

How does a provider submit a telehealth visit with an existing patient that lives in a bordering state?

For providers (e.g., in bordering states) who were previously seeing members in approved locations that met state and/or CMS billing requirements, effective March 17, 2020 for the next 90 days, you may submit your telehealth claim using the primary service address where you would have normally seen the member for the face-to-face visit.

Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc., dba Empire BlueCross. Independent licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.