Updated January 8, 2021

Blue Shield COVID FAQs

for employer groups, brokers, and consultant partners

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Covered services: Medical

1. Will Blue Shield and Blue Shield Promise cover COVID-19 screening and testing?

Yes. Blue Shield and Blue Shield Promise will waive out-of-pocket costs for co-payments, coinsurance, and deductibles for COVID-19 diagnostic testing and related screening services ordered using telemedicine and for testing and screening services ordered or performed in a doctor's office, urgent care, hospital, or emergency room in accordance with applicable state and federal law. [1]

Coverage is provided for diagnostic testing that is determined to be medically appropriate by an individual's healthcare provider in accordance with current accepted standards of medical practice. This may include testing of symptomatic patients, as well as testing of asymptomatic patients when determined to be medically necessary based on an individualized assessment of the patient, such as for an upcoming procedure or recent known or suspected exposure to an infected individual.

This applies to the following plan types:

- Fully-insured and flex-funded employer-sponsored plans
- Plans purchased through Blue Shield directly
- Plans purchased through Covered California
- Medicare Advantage plans
- Medicare Supplement plans
- Self-insured employer-sponsored plans where the plan sponsor elects to pay for copays, coinsurance, and deductibles for COVID-19 testing. These plans are not required to cover these costs. Blue Shield's account teams are working to communicate directly with self-funded clients regarding options for cost-sharing waivers.

Medi-Cal and Cal MediConnect members have no out-of-pocket costs for covered services.

In addition, cost-sharing waivers for Teladoc® visits may no longer apply for some self-funded employer-sponsored plans; clients with questions on this topic should contact their account team.

2. Are Blue Shield and Blue Shield Promise covering serology (antibody) testing under the blanket of COVID-19 testing?

For COVID-19 testing, Blue Shield and Blue Shield Promise are following federal guidance under the Families First Coronavirus Relief Act (FFCRA) and the CARES Act, along with guidance from the Centers for Medicare & Medicaid Services (CMS) and All Plan Letter (APL) 20-006 issued by the California Department of Managed Health Care. Blue Shield Promise is also following applicable guidance from the California Department of Health Care Services for Medi-Cal managed care plans.

In accordance with the above guidance, we are providing coverage without cost sharing for medically necessary diagnostic (PCR or antigen) and diagnostic serological (antibody) testing of patients ordered or administered by a healthcare provider acting within the scope of their license. According to guidance from the FDA and the CDC, antibody tests should not be used as the sole basis for diagnosis, and there are only very limited medically necessary applications for the use of antibody tests in the diagnosis and treatment of COVID-19. The basis of whether COVID-19 diagnostic treatment is medically appropriate for a patient should be determined through evaluation by the healthcare provider based on signs and symptoms of COVID-19.

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Testing performed for non-diagnostic purposes, such as for public health surveillance or return to work purposes, will not be covered.

3. Will Blue Shield cover costs for testing so my employees can return to work?

Blue Shield will comply with the latest DMHC emergency regulation issued on July 17, 2020 regarding COVID-19 testing for "essential workers" and other individuals until the end of the public health emergency. More information on the DMHC regulation and testing guidance is available here.

Return to work testing is not done to improve the health outcome of the employee being tested, and, therefore, would not be covered as a benefit under a Blue Shield health plan, except where testing is required for essential workers under the DMHC emergency regulation noted above. For a definition of who qualifies as an essential worker, please refer to the DMHC FAQ on COVID-19 Testing. This is consistent with coverage for other types of testing that might be administered for the benefit of an employer, such as employer-required drug or alcohol testing, which is not covered as a health plan benefit.

4. How is Blue Shield responding to the California Department of Industrial Relations (DIR) Emergency Regulation issued on 11/30/2020?

The new California Department of Industrial Relations (DIR) Emergency Regulation issued on 11/30/2020 does not mandate health plans to cover COVID-19 testing that employers must provide under the regulation.

Blue Shield is providing coverage without cost-sharing for COVID-19 diagnostic (PCR or antigen) and diagnostic serological (antibody) testing of patients ordered or administered by a healthcare provider and deemed medically necessary in accordance with existing mandates provided by the DMHC, CARES Act, Center for Medicare & Medicaid Services (CMS), and Families First Corona Virus Relief Act (FFCRA).

5. Is Blue Shield and Blue Shield Promise providing and covering the cost of rapid test kits?

On August 27, 2020, the U.S. Department of Health and Human Services (HHS) announced the deployment of 150 million rapid test kits. Rapid testing is not new, but it is becoming more available. These kits use antigen testing, which allows test samples to be processed at the point of testing, as opposed to the Polymerase Chain Reaction (PCR) testing, which must be processed in a laboratory. While rapid testing can provide faster results, the accuracy of rapid testing is lower than PCR tests. An overview of COVID-19 testing, provided by the CDC, can be found here. The availability of these recently deployed rapid tests will primarily be determined at the state level.

Cost coverage for rapid test kits aligns with coverage for other COVID-19 diagnostic testing under federal law.[1] If rapid testing is determined to be medically necessary by an individual's healthcare provider in accordance with current accepted standards of medical practice, it is a covered benefit with no member cost sharing. This coverage requirement applies to both fully insured and self-funded plans. Members enrolled in DMHC fully insured group and IFP plans who qualify as "essential workers" may obtain a rapid test without a provider order under the DMHC emergency regulation on COVID-19 diagnostic testing, but these members must first contact Blue Shield about in-network testing options. Cost shares will apply based on the member's in-network benefits.

6. What is pooled testing?

Pooled testing entails the collection of samples from multiple people that are run as a combined diagnostic test to generate a single collective result. This option may be used by labs as an alternative to individual testing, which may take longer and require more testing

resources (such as reagents) than pooled testing. Only the labs will decide if pooled testing can be used or not. It cannot be ordered or requested in advance at this time. Currently, pooled testing is ordered, billed, paid and reported as if it was individual testing.

7. Are Blue Shield and Blue Shield Promise covering the cost of treatment for COVID-19?

Yes. Blue Shield will waive co-payments, coinsurance, and deductibles for treatment for COVID-19 received between March 1, 2020 and January 31, 2021.[1]

This applies to the following plan types:

- Fully-insured and flex-funded employer-sponsored plans
- Plans purchased through Blue Shield directly
- Plans purchased through Covered California
- Medicare Advantage plans
- Medicare Supplement plans
- Self-insured employer-sponsored plans where the plan sponsor elects to pay for copays, coinsurance, and deductibles for COVID-19 testing. These plans are not required to cover these costs. Blue Shield's account teams are working to communicate directly with self-funded clients regarding options for cost-sharing waivers.

Medi-Cal and Cal MediConnect members have no out-of-pocket costs for covered services.

8. When did Blue Shield start to process claims with no cost-sharing for COVID-19-related services?

On March 18, 2020, Blue Shield began processing member co-pays, coinsurance, and deductibles at no cost. Any claims received between January 27, 2020 and March 18, 2020 will be re-adjudicated at zero dollars for COVID-19-related *testing and screening* services in accordance with state and federal law.

9. What treatments are covered?

Any treatments for COVID-19 from doctors, hospitals, and other health care professionals in a plan's network from March 1, 2020 through December 31, 2020 are covered. Providers must use proper diagnosis and procedure codes related to COVID-19 for Blue Shield to waive member deductible, copay, and coinsurance liability for treatment.

10. Does Blue Shield and Blue Shield Promise cover at-home Coronavirus test kits and will the co-payment be waived?

At this time, Blue Shield and Blue Shield Promise only cover self-administered test kits that are FDA-approved, emergency use authorized, or authorized under other guidance from the Secretary of the Department of Health and Human Services consistent with the federal CARES Act. Other self-administered tests available on in the market may not be accurate and are not covered.

In addition, Blue Shield and Blue Shield Promise require that self-administered tests are ordered by a healthcare provider, sent to the approved laboratory specified on the kit, and processed in accordance with FDA and other guidance, as applicable. This policy is in accordance with applicable legislation, including the federal CARES Act. Blue Shield and Blue Shield Promise will not cover self-administered test kits that fail to meet the conditions specified above. Members should call the phone number on the back of their member ID card to confirm coverage.

Please see #3 above for essential worker requirements set forth by the DMHC emergency testing regulation.

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11. When a vaccine becomes available, will it be covered in preventive health benefits?
Blue Shield of California and Blue Shield Promise will cover FDA approved or emergency use authorized COVID-19 vaccines without cost sharing, consistent with the requirements of federal law, including the guidelines in the Fourth Interim Final Rule (effective Nov 2, 2020) issued by the US Departments of Labor, Treasury, and Health and Human Services. In general, federal law requires coverage of COVID-19 immunizations within 15 business days after the immunization has been recommended by the Advisory Committee on Immunization Practices (ACIP) and adopted by the CDC, regardless of whether it appears on the Immunization Schedules of the CDC for routine use.

This applies to both self-funded and fully insured plans. Self-funded plans are required to apply the same coverage that applies to any ACA-mandated preventive services. The coverage mandate for the vaccine does not apply to grandfathered plans, but those plans may choose to cover the vaccine without cost-sharing. For grandfathered plans that do not cover the vaccine without cost-sharing, vaccinations will still be available to enrollees without cost. Vaccine providers have other sources of funding for vaccine administration, and providers are prohibited from seeking reimbursement directly from individuals who are being vaccinated.

12. What is the member cost-share for the COVID-19 vaccine? Will members pay any out-of-pocket costs for the vaccine if they haven't met their deductible for the year yet?
Member cost share is $0 for the vaccine and its administration. Vaccine coverage will not be subject to any deductibles.

13. When a vaccine becomes available, when will I be able to receive it?
Initial availability will be limited with prioritization given to the following groups:

- Healthcare personnel
- Non-healthcare essential workers
- Adults with high-risk medical conditions who possess risk factors for severe COVID-19 illness
- People 65 years of age and older (including those living in Long Term Care Facilities)

For more information, please refer to the CDC's COVID-19 Vaccination Program Interim Playbook.

14. Who is the vaccine recommended for? Should members who have had COVID-19 still receive the vaccine?
The Pfizer vaccine is approved for persons 16 years of age and older. The Moderna vaccine is approved for persons 18 years of age and older. Currently, there is no CDC guidance regarding getting the vaccine after having active disease.

15. Do I need provider order to get the COVID-19 vaccine?
According to the Fourth Interim Final Rule, a provider order is not needed to obtain a COVID-19 vaccine. Please note that initial vaccine availability may be limited. See above for information on prioritization.

16. What is the administrative cost for the COVID-19 vaccination and who is responsible for paying?

a. The COVID-19 vaccine and administrative costs are covered as preventive services without cost-sharing or balance billing to the member. This includes multiple doses, if needed or required.
b. This coverage applies to both in and out-of-network providers during the COVID-19 Public Health Emergency. Once the public health emergency ends, plans may choose to limit coverage to in-network providers.
c. Self-funded plans are required to apply the same coverage that applies to any ACA mandated preventive vaccine. The coverage mandate for the vaccine does not apply to grandfathered plans, but those plans may choose to cover the vaccine without cost-sharing. For grandfathered plans that do not cover the vaccine without cost-sharing, vaccinations will still be available to enrollees without cost. Vaccine providers have other sources of funding for vaccine administration, and providers are prohibited from seeking reimbursement directly from individuals who are being vaccinated.

17. Where can I get a vaccine? Is the COVID-19 vaccine covered at both in- and out-of-network providers?

Blue Shield is closely monitoring announcements from various governing agencies regarding the availability and disbursement of COVID-19 vaccinations. Blue Shield will comply with state and federal regulations and share information as it becomes available.

Additional information about the vaccine and the government's plan for release is available on the CDC FAQ website. Vaccine Finder and Vaccines.gov also offer more information to help members identify vaccine locations.

The vaccine will be covered at both in- and out-of-network providers.

18. Will vaccines be available at all pharmacies in the Blue Shield retail pharmacy network?

The vaccines are being distributed to a limited number of providers at this time. Please contact your desired pharmacy to ask if they have received a vaccine supply or go to one of the following websites:

- https://www.vaccines.gov/get-vaccinated/where
- https://www.cdc.gov/vaccines/adults/find-vaccines.html
- https://vaccinefinder.org/

19. Are members required to remember the manufacturer of their first COVID-19 vaccine to ensure the second is from the same manufacturer?

No. Providers will have access to a vaccine registry to ensure members get the proper vaccine for the second dose.

20. Are the COVID-19 vaccines safe for members to get?

The U.S. vaccine safety system ensures that all COVID-19 vaccines are as safe as possible. The COVID-19 vaccines went through rigorous clinical trials with thousands of participants. In each of these trials, participants were closely monitored for any health risks and side-effects. Once the trial results indicated that the vaccine was safe and effective, it was authorized by the FDA for emergency use.

California has formed a Scientific Safety Review Workgroup which will help ensure the COVID-19 vaccine meets safety requirements.

The CDC and FDA are also closely monitoring side effects and adverse outcomes on an ongoing basis. Any concerns will be reported by the agencies through the Vaccine Adverse Event Reporting System (VAERS).

21. Are there any side effects of the COVID-19 vaccines?

Minor side effects are normal with most vaccines including the COVID-19 vaccines but are also brief. We will know more about side effects of the COVID-19 vaccines as more information becomes available.

Early reports show some short-term side effects may include:

- Fatigue
- Fever
- Chills
- Headache
- Muscle aches
- Joint pain
- Pain at the injection site

These symptoms are signs that the body is building immunity and may temporarily be uncomfortable.

In very rare cases, severe reactions, such as with allergies (anaphylaxis) may occur in people who have had similar problems in the past. Members who have had severe allergic or other reactions in the past should be observed by healthcare professionals after receiving the vaccine to ensure safety. Members should talk to their doctor in advance about any concerns or questions on side effects.

22. How many COVID-19 vaccine doses are needed?

Most COVID-19 vaccines available in the United States require recipients to receive two shots to get the most benefit. There is a waiting period between the two shots that varies depending on the manufacturer. Pfizer's vaccine doses are 21 days apart and Moderna's vaccine doses are 28 days apart that were found in studies to give the best response.

To get the best results, it is important to get both doses of the vaccine. It takes time for the body to build up the antibodies required for immunity following vaccination, and the second dose builds on the effects from the first.

23. Is wearing a mask still advised after getting the COVID-19 vaccine?

Yes. Experts still need to learn more about the protection that COVID-19 vaccines provide under real-life conditions, per California's COVID-19 website. In particular, it is unclear if people who have been vaccinated can still spread the disease.

This means recipients of the vaccine should continue to use all the tools available to help stop this pandemic. This includes:

- Wearing masks
- Washing hands often
- Social distancing
- Minimizing mixing with other households

Learn about other FAQs about the COVID-19 vaccine from the Centers for Disease Control and Prevention.

24. How do I know if my employees are part of the first phase of the vaccination?

Blue Shield understands the importance of reliable information and urgency to receive the COVID-19 vaccination. Planning ahead, we recommend employers to review the CDC's COVID-19 Vaccination Program Interim Playbook and the California Department of Public Health COVID-19 Vaccine Planning FAQ guidelines to determine the vaccine rollout plan.

25. Can I mandate vaccinations as an employer? How should I, as an employer, handle maximizing vaccinations to either ensure the safety of my employees already back to work or get my employees back to work as quickly as possible?

Employers should consult with their internal and external legal teams regarding these types of questions and compliance with state and federal regulatory guidelines for work performance mandates, tracking health/vaccinations, and implementing safety in the workplace. Blue Shield cannot provide employers with legal or compliance advice regarding employment practices.

26. How do I effectively and legally confirm my employees have been vaccinated for COVID-19 including all recommended dosages?

Employers should comply with state and federal guidelines on privacy and seek guidance from their legal and privacy advisors. Blue Shield cannot provide employers with legal or compliance advice regarding employment practices.

27. Is BSC assisting employers with on-site vaccinations?

California is expected to have COVID-19 vaccines available by the summer of 2021. Disbursement is limited and controlled at the state level and follow allocation guidelines set forth by the CDPH. For more information on COVID-19 Vaccines, see COVID19.CA.GOV

28. Are you aware of any limitations in coverage for treatment of an illness/virus/disease that is part of a pandemic?

No. Blue Shield standard contracts do not have exclusions or limitations on coverage for services for the treatment of illnesses that result from a pandemic.

29. Do HMO members still need to go through their allocated primary care provider (PCP) to get COVID-19 testing and treatment?

Yes, except in emergency situations.

30. If a member visits an out-of-network provider for COVID-19 treatment, will it be covered?

In the case of a medical emergency, care provided by in-network and out-of-network providers will be covered for all plans. Outside of an emergency, members should seek care from in-network providers to save money and to prevent having to pay out-of-pocket.

If a member has a plan with out-of-network covered benefits, Blue Shield will cover both in-network and out-of-network copayments, coinsurance, and deductibles for COVID-19 covered benefits. However, out-of-network providers may charge more than the covered benefit amount. In this case, the member may be responsible for paying the difference.

31. Is Blue Shield ensuring that COVID-19 testing and treatment is affordable for members with high-deductible plans?

Blue Shield is waiving co-payments, coinsurance, and deductibles for COVID-19 testing,

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screening, and treatment in accordance with state and federal law and in the same manner as for other commercial plans. IRS guidance (issued March 11, 2020) clarified that these cost-sharing waivers are permissible for high-deductible health plans and will not cause enrollees to become ineligible for contributions to their health savings accounts or cause a plan to lose its status as a high-deductible health plan.

32. For HMO Blue Shield Away from Home Care members in another state: how do they find out what type of testing is covered, cost of coverage, and where to get tested for COVID-19 and antibodies?

Away from Home Care enables members to receive Guest Membership benefits from other participating Blue Plans while traveling outside their Home Plan service area. The member will need to contact the Blues plan that they are enrolled in by calling the Member Services number on the back of their Blue Shield member ID card.

33. How are Blue Shield and Blue Shield Promise handling treatment and testing claims for pop-up/temporary private or government facilities?

We expect claims for patients from any temporary facilities to match the network status of the referring provider and/or entity responsible for the pop-up facility. Applicable network limitations will apply according to the terms of a member's plan. In the case of a medical emergency, care provided by in-network and out-of-network providers will be covered for all plans.

Pop-up testing performed for public health surveillance or employment purposes will not be covered by Blue Shield commercial plans. Testing for these purposes may be paid for by the government entity or employer that arranged for the services, or by the member.

Covered testing is limited to FDA-approved or emergency use-authorized COVID-19 tests ordered by an appropriate provider acting within the scope of their license and based on a determination that the testing is medically appropriate for the individual, in accordance with accepted standards of current medical practice.

For on-site testing to be covered by a Blue Shield plan, the coverage requirements below must be met:

- The selected onsite testing vendor must comply with federal and state requirements for COVID-19 testing coverage
    - This means that, for DMHC-regulated commercial plans, members are identified as essential workers per DMHC guidelines (Please see External FAQ #2 on the DMHC Emergency Regulation). Essential worker testing is covered only under Blue Shield's DMHC-regulated commercial plans.
    - Or there is a provider order for medically necessary tests (This may be an option for employers that have suspected exposure or an outbreak at their facility)
- For testing to be covered, the vendor, lab, provider, employer, or member must submit a claim to Blue Shield for each individual tested. There is no way to reimburse pooled/lumped costs since employer groups may have members who belong to other health plans besides Blue Shield.
- If the above coverage requirements are not met, Blue Shield will not cover testing and the employer will be responsible for all costs.

34. Will there be an extension to current prior authorizations for elective surgeries or will providers need to resubmit for approval? Will there be a difference between inpatient and outpatient procedures?

Blue Shield and Blue Shield Promise have extended the timeframes for all prior authorization requests to 180 days from the original request in an effort to mitigate the impact of shelter-

at-home protocols and provider office closings. This applies to both inpatient and outpatient procedures but does not apply to urgent/emergent admission stays that may occur during this time.

[1] Please note that COVID guidance is evolving rapidly and this information may be subject to change based on any new legal or regulatory developments.

Covered services: Pharmacy benefits

1. Are there any prescription medications to treat COVID-19?

The drugs chloroquine and hydroxychloroquine had received FDA authorization for emergency use (EUA) to treat hospitalized (inpatient) patients only; however, as of June 15, 2020, these drugs had their EUA revoked and will not be covered for COVID-19 treatment for inpatient members or for prophylactic purposes. Outpatient treatment still consists of symptom treatment and/or supportive care.

The drug Veklury (remdesivir) has received emergency use authorization from the FDA to include treatment of all hospitalized adult and pediatric patients with suspected or laboratory confirmed COVID-19, irrespective of severity of disease. This drug is NOT approved by the FDA for any other use.

Blue Shield is closely monitoring announcements from the Centers for Disease Control (CDC) and Food and Drug Administration (FDA) for prescription drugs and vaccines that become available for the treatment or prevention of coronavirus to support access for our members.

There are currently two products that have the FDA's Emergency Use Authorization: Carisivimab/ imdevimab, made by Regeneron, and Bamlanivimab, made by Eli Lilly. Both Carisivimab/imdevimab and Bemlanivimab are approved for the treatment of mild to moderate COVID-19 in adults and pediatric patients (age ≥12 years, weight ≥40 kg) with positive SARS-CoV-2 test, and who are at high risk for progressing to severe COVID-19 and/or hospitalization. These medications are currently paid for by the US government. The administration of the drugs will be covered as applicable by the members' health plans.

2. What are monoclonal antibodies? What are the monoclonal antibodies used to treat COVID-19 and when can they be used?

Monoclonal antibodies are laboratory-produced molecules engineered to serve as substitute antibodies that can restore, enhance or mimic the immune system's attack on cells. The monoclonal antibodies are designed to block viral attachment and entry in to human cells, thus neutralizing the virus. It is designed to limit viral replication and may be effective for the treatment of COVID-19 in patients who are at high risk for progressing to severe COVID-19 and/or hospitalization.

There are currently two products that have the FDA's Emergency Use Authorization: Carisivimab/ imdevimab, made by Regeneron, and Bamlanivimab, made by Eli Lilly.

Both Carisivimab/imdevimab and Bemlanivimab are approved for the treatment of mild to moderate COVID-19 in adults and pediatric patients (age ≥12 years, weight ≥40 kg) with positive SARS-CoV-2 test, and who are at high risk for progressing to severe COVID-19 and/or hospitalization.

3. Are monoclonal antibodies given at the hospital? How are they given?

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No, they are given in the outpatient setting by a home infusion nurse in your home, physician's office, or an outpatient infusion center. Neither drug is authorized for patients who are hospitalized or require oxygen therapy.

Both products are given as a one-time dose. They are given intravenously through a needle that is placed in the patient's vein by a nurse or doctor. Patients will only need to take one of these drug regimens

4. How are the monoclonal antibodies being distributed for use? What is the availability in CA?

The Department of Health and Human Services (HHS) is coordinating with both manufacturers to ensure that all states receive an allocation of the drugs based on the number of confirmed COVID cases and number of hospitalized patients on a weekly basis. Supply of the drugs is limited and CA has received a supply of the medications.

More information may be found at the following website:
https://www.phe.gov/emergency/events/COVID19/investigation-MCM/cas_imd/Pages/faq.aspx

5. Are members allowed to fill their prescriptions earlier or have larger fill or refill amounts to offset difficulties with getting medications?

For the duration of the public health emergency, Blue Shield and Blue Shield Promise will waive early refill limits on prescription medications. This applies to our commercial, Medicare, Cal MediConnect, and Medi-Cal members.

Blue Shield does not recommend stockpiling medications. However, early refill limits have been adjusted so that members can refill an extended supply of their medication according to their benefit. For any questions regarding early refills, members may call the Members Services number on the back of their Blue Shield member ID card.

6. What happens if there are shortages of medications due to this pandemic?

In the event of a prescription drug shortage, Blue Shield has a standard process in place to take immediate steps so that members have access to alternative medications to treat their condition. Blue Shield's process includes monitoring drug shortage notifications from the FDA, evaluating and changing formulary coverage, and if necessary, identification of alternative medications to treat the same condition. Affected members and their prescribers will be notified of the shortage and applicable treatment alternatives in the event of a shortage.

7. Can Blue Shield and Blue Shield Promise members receive home health infusion by a nurse in their home instead of going to a hospital in order to avoid exposure to COVID-19, and help reduce traffic at the hospital?

If members normally receive drug infusion services in a facility, they should talk with their doctor about whether their drug infusion services should be continued and if they can be administered in home instead. If the member's physician or authorized prescriber determines they can safely receive drug infusions at home, Blue Shield and Blue Shield Promise members are eligible for physician-ordered and plan authorized home infusion services. To find a home infusion provider, members can search our Find a Doctor website or call Member Services at the number on the back of Blue Shield member ID card.

- Blue Shield Commercial and Medicare Advantage Find a doctor tool
- Blue Shield Promise Medicare Find a doctor tool

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- Blue Shield Promise Cal MediConnect Find a doctor tool
- Blue Shield Promise Medi-Cal Find a doctor tool

8. How can a member practice social distancing and conveniently access their prescription medications?

Members can practice social distancing by:

- Contacting their local retail pharmacy about delivery services. Many pharmacies are offering free delivery service during this time of social distancing.
- Filling their medications at pharmacies with drive-through pick-up options.
- Filling extended day supply of maintenance medications.
- Commercial members can access 90-day supplies of maintenance medications used to treat chronic conditions through our mail-service pharmacy, CVS Caremark. Members can contact their doctor to switch to a 90-day prescription.
- Medicare and Cal MediConnect members can also fill a prescription for a 90-day supply of maintenance medications at retail pharmacies in addition to our mail service pharmacy. Call the local pharmacy to ask about delivery or use the drive-thru window when picking up prescriptions, when possible.
- Medi-Cal members can also fill a prescription for up to 100-day supply of their medications at retail pharmacies and through our mail service pharmacy.

For more information on how to fill extended day supply prescriptions through CVS Caremark, visit our website at and select "Mail Service Pharmacy" under the "Pharmacy Networks" section. Members can also call CVS Caremark directly at (866) 346-7200.

Covered services: Virtual care

1. Does your standard employer group plan contract cover telemedicine?

Telemedicine services are covered under Blue Shield's standard plan designs for fully insured and self-funded (ASO and Shared Advantage/Shared Advantage+), as follows:

- For all plans, telemedicine services are available as a covered benefit through those network providers that offer such services, including Mental Health Service Administrator participating providers.
- For fully insured plans, telemedicine services are also available through Teladoc and Nurse Help 24/7.
- For self-funded plans, telemedicine services may also be available through Teladoc and Nurse Help 24/7, if the plan sponsor has elected to offer those programs.

In addition, Blue Shield is expanding access to telemedicine services in response to COVID-19 by allowing providers to offer COVID-19 screening services using an expanded range of telemedicine platforms, performed appropriately during the COVID-19 public health emergency. Please visit the website for further detail regarding the availability of telemedicine services.

2. Will Blue Shield cover Teladoc COVID-19 services?

Yes. Copays and co-insurance for any Teladoc visits, medical and behavioral health[2], will be waived for members enrolled in all Blue Shield commercial plans and all employer-sponsored plans that offer Teladoc until December 31, 2020, whether or not related to COVID-19. Members enrolled in Blue Shield's Trio, Tandem, and Medicare Advantage and Medicare Supplement plans already enjoy $0 out-of-pocket costs for Teladoc medical services.

3. If a member pays for the co-payment, either through an office visit or Teladoc, because the provider requested payment at time of service, will they be reimbursed?

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If a member is improperly charged for a co-payment, the member should call the number on the back of their member ID card and Customer Care will work with them to get a reimbursement issued.

[2] For Blue Shield plans that offer Teladoc dermatology services, the waiver of cost sharing does not apply to those services.

Covered services: Behavioral health

1. What services does Blue Shield offer for members with anxiety over this outbreak?

Blue Shield is making Teladoc health, including behavioral health services, available with no member cost sharing through December 31, 2020 for all members with access, including fully insured commercial plans.

Blue Shield Promise Medicare Advantage, Cal MediConnect, and Medi-Cal members will be able to leverage tele-behavioral health services through Teladoc as well as Beacon Health Options. Members can log in to their online account to see if they have access to Teladoc. Members in Medicare Supplement plans and IFP grandfathered plans have access to Teladoc behavioral health services via a dedicated gateway at https://member.teladoc.com/bsc.

During this time, all Teladoc behavioral health services will be exempt from copays, regardless of the reason for the visit, including encounters with psychiatrists, psychologists, licensed clinical social workers, and marriage family therapists.

Not all ASO only and other self-funded groups offer Teladoc services. Members in self-funded plans can verify the availability of Teladoc services with their employer or by calling Blue Shield's Customer Care.

Mental health services also continue to be available from providers other than Teladoc. If the Evidence of Coverage (EOC) or Certificate of Insurance (COI) states that mental health services are available through the Mental Health Services Administrator (MHSA) network, members can search for providers in the MHSA network through the provider directory. The standard office visit copay applies to MHSA tele-behavioral health appointments.

Blue Shield also provides our LifeReferrals 24/7 SM Employee Assistance Program (EAP) to all fully insured large (101+) groups and it is available as an optional buy-up for self-funded employers. The LifeReferrals 24/7 program offers access to support services 24 hours a day, seven days a week, including assessments and referrals for consultations for health and psychosocial issues. Professional counselors can provide confidential telephone or in-person support by appointment.

Covered services: Specialty

1. Will Blue Shield cover the cost of personal protective equipment (PPE) required by the American Dental Association?

After careful consideration it was determined that we will discontinue our $10 PPE benefit after 8/31/20. This decision was based on programs now available to Dental Providers,

including a $10M relief package offered by Dental Benefit Provider (DBP). Our program was intended to serve as a stop-gap while other programs were being established.

For dates of service on or before 8/31/20, the provider will include the PPE charge on the claim for reimbursement. Blue Shield's dental plan administrator is notifying network providers of this program so members should not be billed. Should a member visit an out-of-network provider and receive PPE charges, they can submit a claim to be reimbursed for the charge.

2. **Will there be a special enrollment period for dental and vision plans?**
Yes. For Small Group (1-100), employer groups may enroll new members off-anniversary through a Special Enrollment Period (SEP) through November 30, 2020, with December 1, 2020 as the latest effective date. This SEP is for employees who previously declined dental and vision coverage for themselves or their dependents. Enrollment requests must be received on or before the 1st of the month for which enrollment is being requested.

This applies to all fully insured employers; self-funded plan sponsors typically determine eligibility of group coverage, which is described in their plan document.

3. **How are Blue Shield of California Dental members being served during the COVID-19 outbreak?**
Most dental offices have resumed normal in-office hours with enhanced COVID-19 protocols.

All dental plans include tele-dentistry codes to allow for virtual dental visits if someone does not feel comfortable going into the office.

To take advantage of tele-dentistry, a provider would need to submit either one of 2 covered codes (D9995and D9996). These benefits are covered in full to the member. The member can call the customer service number on the back of their ID card for tele-dentistry or provider information.

Eligibility and enrollment

1. **Will there be a special enrollment period for individuals who wish to enroll at this time?**
Yes. For Small Group (1-100), employer groups may enroll new members off-anniversary through a Special Enrollment Period (SEP) through November 30, 2020, with December 1, 2020 as the latest effective date. This SEP is for employees who previously declined coverage for themselves or their dependents. Enrollment requests must be received on or before the 1st of the month for which enrollment is being requested.

This applies to all fully insured employers, and includes enrollment for medical plans, dental plans, and vision plans. Self-funded plan sponsors typically determine eligibility of group coverage, which is described in their plan document.

Blue Shield will also align with Covered California and have a Special Enrollment Period for Individual and Family as a result of the current COVID-19 outbreak.

2. **Is Blue Shield enforcing active-at-work and minimum work hours?**
Fully insured groups: The terms of the group service agreement continue to apply to employee eligibility for coverage. Please refer to your agreement, and note that there are provisions in most group service agreements that may allow for continued coverage for

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members who are impacted by a temporary suspension of work or temporary reduction of hours in certain circumstances (such as a layoff, furlough, or approved leave of absence), if permitted under the employer's policies regarding coverage, under the following conditions:

- If the subscriber ceases active work because of a disability due to illness or bodily injury, or because of an approved leave of absence or temporary layoff, payment of dues for that subscriber shall continue coverage in force in accordance with the employer's policy regarding such coverage.
- If the employer is subject to the California Family Rights Act of 1991 and/or the Federal Family & Medical Leave Act of 1993, and the approved leave of absence is for family leave pursuant to such Acts, payment of dues for that subscriber shall keep coverage in force for the duration(s) prescribed by the Acts. The employer is solely responsible for notifying employees of the availability and duration of family leaves.

ASO/SA+: Self-funded groups/Plan sponsors typically determine eligibility and continuation of group coverage, which should be described in the plan document. If the plan document does not detail furlough or reduction-in-force situations, the plan sponsor would have to make a determination of how to proceed with employees in these situations. For example, employees (and their dependents) who lose eligibility for coverage due to a furlough or reduction in force may be eligible to elect continuation coverage under COBRA or Cal-COBRA.

If the employer/plan sponsor continues to pay administrative fees, claims, and stop loss premiums (if applicable) for the workforce that is laid off/furloughed and not actively at work in the same manner as prior to COVID-19 crisis, there would be no change in coverage.

3. Will Blue Shield allow customers to continue employee health benefits if part of the workforce is laid-off in response to the COVID-19 crisis?

Fully insured groups: Yes, assuming the employer continues to remit premium payments for workforce that is laid off and not actively at work in the same manner as prior to COVID-19 crisis, there would be no change in coverage.
Self-funded groups: Yes, assuming the plan sponsor continues to pay administrative fees, claims, and stop loss premiums (if applicable) for the workforce that is laid off and not actively at work in the same manner as prior to COVID-19 crisis, there would be no change in coverage.

4. If my employees are laid off, what are their options for continued medical coverage?

- Employees can remain on group plan under the conditions described above; *or*
- Employees can elect Cal-COBRA/COBRA, if eligible, and will be liable to pay the full costs of coverage (unless their employer chooses to subsidize Cal-COBRA/COBRA premiums); *or*
- Employees can enroll in the individual marketplace (e.g., through Covered California). Blue Shield and Covered California open enrollment has been extended through June 30th as a result of the current COVID-19 outbreak. Employees may benefit from government subsidies to help pay for these premiums.

5. If an employee is laid off and then re-hired, how long is the waiting period before they can join the medical plan?

Fully insured groups: Blue Shield standard provision allows for waiving of waiting period if rehired within six months of cancellation of coverage. Check your contract for further details.

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Self-funded groups: The plan sponsor/employer is responsible for eligibility determinations and should refer to the applicable provisions of their plans regarding eligibility and waiting periods for employees who are re-hired.

6. Can groups temporarily suspend their medical plans if they shut down, rather than cancel and re-write?

Groups may not temporarily suspend their plans.

7. Can Blue Shield provide a group with a COBRA plan that is different from the plan the group offers to its active employees?

Groups are responsible for COBRA administration. In general, COBRA enrollees cannot be offered a plan that is different from the plan(s) offered to active employees, and a COBRA qualified beneficiary is entitled to elect COBRA continuation coverage only in the plan in which they were enrolled at the time of their COBRA qualifying event. If the employer offers multiple plans, a COBRA enrollee generally must wait until open enrollment to change plans. However, Blue Shield is currently offering a special enrollment period that may allow a COBRA enrollee to make a plan change outside of open enrollment if the employer offers multiple plans. Any plan options made available to COBRA enrollees would also need to be available for active employees, who would also be eligible for the special enrollment opportunity that is being offered by Blue Shield. See other FAQ for details on the special enrollment opportunity.

8. How is Blue Shield responding to the Department of Labor guidance regarding the extension of certain COBRA deadlines during the COVID-19 Outbreak Period?

The U.S. Department of Labor (DOL) announced on April 28 guidance for regulatory relief providing for "extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak." The DOL notice requires that from March 1, 2020 until 60 days after the announced end of the national public health emergency, standard regulatory timeframes related to COBRA continuation coverage, special enrollment, claims, and appeals should be disregarded. This guidance applies to all health plans subject to the Employee Retirement Income Security Act of 1974 (ERISA).
The following Blue Shield plans are subject to ERISA:

- Small business (1-100) plans
  - Note: Federal COBRA does not apply for groups under 20 employees
- Large group (101+) fully insured plans
- Large group (101+) self-funded/Administrative Services Only (ASO) plans
- Shared Advantage and Shared Advantage Plus plans

Non-ERISA plans include government and church-sponsored plans.

For more information, please refer to our DOL guidance FAQs and the DOL website.

9. Is Blue Shield providing plan election changes in response to the recent IRS guidance issued in May?

Blue Shield will continue to offer the following plan election changes that were in place prior to this guidance.

Large Group (100+): Blue Shield is offering the ability to downgrade benefits off-cycle on a case-by-case basis. With the exception of adding Trio HMO and/or Tandem plans, this will not be a special open enrollment opportunity and employers cannot introduce new plans. Employees and their dependents will remain in their same plan type with downgraded benefits. For example, buy-down selections must be consistent with the current plan type offered by the group: PPO plan to PPO or HMO plan to HMO.

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Please note that Blue Shield is not allowing a special open enrollment off-anniversary that would allow all employees to choose from any of the plans offered by the employer.

Small Group (1-100): Blue Shield is offering groups the ability to downgrade to a leaner plan design off-cycle. Buy-down selections must be consistent with the current plan type offered by the group: PPO plan to PPO or HMO plan to HMO. Employees can choose from any of the employer group's current plan offerings as long as they are choosing a downgraded plan. The rates for employees who choose a buy-down plan off-cycle will be based on the age of the member at the time of the change.

In addition, Blue Shield is still offering its previously announced Special Enrollment Period (SEP) for Small Group. Blue Shield's COVID-19 SEP allows individuals who previously declined coverage for themselves and/or their dependents to enroll without any of the standard qualifying life events. This COVID-19 SEP applies only to fully insured groups; self-funded plan sponsors typically determine eligibility of group coverage. The Blue Shield SEP will end November 30, 2020 unless otherwise announced.

10. How is Blue Shield responding to the guidance regarding the extension of certain COBRA deadlines during the COVID-19 Outbreak Period?

According to the guidance, the Outbreak Period must be disregarded when calculating a qualified beneficiary's 60-day election period for COBRA continuation coverage, as well as when determining the date on which a qualified beneficiary is required to make COBRA premium payments. COBRA administration is generally the employer group's obligation, and Blue Shield cannot provide legal or compliance advice on how to satisfy applicable COBRA requirements. We are providing the information below to address how Blue Shield will handle retroactive enrollment and disenrollment requests related to a group's implementation of the extended COBRA deadlines.

If a group wants to keep a COBRA enrollee's coverage in force, the group is required to pay the applicable premium. If the group has not received the premium payment from the COBRA qualified beneficiary, Blue Shield will not make an exception to this requirement. In this case, the group would have two options:

(1) Pay the premium on behalf of the COBRA enrollee to keep the coverage in force and try to collect the premium from the COBRA enrollee; or
(2) Disenroll the COBRA enrollee until the COBRA enrollee pays the applicable COBRA premium, at which point the group could seek to retroactively enroll the individual.

If a group follows option (1) and the COBRA enrollee fails to timely pay the required COBRA premium, the group may want to retroactively disenroll the individual and obtain a refund of the premium paid on the individual's behalf. A group's ability to request retroactive disenrollment and obtain a premium refund is defined in the group agreement. Blue Shield's group agreements generally limit retroactive disenrollment requests to a period of 60 or 90 days (groups should check their agreements for the applicable limitation). Blue Shield will not make exceptions to permit retroactive disenrollment going back further than what is permitted under the group's agreement, even if the retroactive disenrollment is related to the extended COBRA deadlines.

For option (2), Blue Shield will extend retroactive enrollment timelines beyond the current limitations in our group agreements to permit employers to make retroactive enrollments that are required to comply with the extended COBRA deadlines. For example, if an employer delays enrollment of a COBRA qualified beneficiary who has elected COBRA continuation coverage until the individual provides timely payment of the applicable COBRA premiums, Blue Shield will permit retroactive enrollment even if requested going

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back further than the retroactive enrollment period stated in the applicable group agreement.

Similarly, if an employer group chooses to disenroll an individual who has delayed payment of COBRA premiums based on the extended premium payment deadline, and the group later wants to re-enroll the individual retroactively after receipt of the applicable COBRA premium payments, Blue Shield will permit the retroactive enrollment even if it exceeds the retroactive enrollment period stated in the applicable group agreement.

In all cases, for Blue Shield to process the retroactive enrollment, the group would need to pay all applicable premiums for the period of retroactive enrollment.

The information provided above is for informational purposes and is not an attestation that any of the options discussed above will satisfy a group's COBRA compliance obligations. Groups may have additional COBRA compliance obligations related to the extended COBRA deadlines and should consult their attorneys or compliance advisors regarding any legal or compliance questions.

For more information, please refer to our DOL guidance FAQs.

Business operations: Blue Shield of California operations

1. **Will there be any disruption or delay in processing claims?**
   Over the last several years, Blue Shield has made significant investments in its technological infrastructure and contingency planning. We are happy to report that there have been no material changes in claim reporting lag, claim processing lag, or other claim-payment related procedures as a result of new business protocols resulting from the pandemic.

2. **With Blue Shield transitioning to teleworking, what will be the impact for Customer Operations, including call centers?**
   We have augmented staff through cross-training and are actively working with our vendors to increase their staffing levels. As a result, there has been no material changes in processing or service levels in our call centers, utilization management, or case management.

3. **What about medical management?**
   We are pleased to share that we have no disruptions for medical management, and we will continue to monitor the situation so that our members have access to care. The Blue Shield of California team is assessing current practices and reviewing service level trends for both utilization management and case management and actively adjusting practices as needed.

4. **Are Blue Shield's claim processing times going to be affected by COVID-19? This includes claim lag times (which affects a group's IBNR reserves, paid claim projections and cashflows) and stop loss reimbursement times?**
   There is no anticipated impact to Blue Shield's claim processing times and advance funding groups with Blue Shield Life stop loss.

5. **Is Blue Shield prepared to address any appeal that may come in if a provider or patient believes the claims were not processed correctly according to new requirements?**
   Blue Shield is preparing its grievances and appeals divisions (for providers and enrollees) to

address any appeal that may come in if a provider or patient believes the claims were not processed correctly in the implementation of new regulatory requirements.

6. **Does Blue Shield expect to keep their timelines for renewal delivery?**
Yes. Blue Shield expects to keep our timelines for renewal delivery.

7. **Will Blue Shield and Blue Shield Promise allow the use of electronic signature services?**
Blue Shield and Blue Shield Promise will accept the use of electronic signature services (such as DocuSign) for policy documents, if initiated by the policyholder/producer. We are also working to operationalize the use of such services when sending signature requests to policyholders/producers.

8. **Will the new Summary of Benefits and Coverage (SBCs) include COVID-19 related coverage?**
Blue Shield has provided members and plan sponsors with notice of COVID-19 related coverage changes that would affect the content of previously issued SBCs for the current plan year. This notice has been provided in various forms, including direct email communications and postings on Blue Shield's website.

Blue Shield's approach for providing this information is consistent with the applicable SBC regulations and other guidance regarding the provision of required notices of coverage modifications that would affect the content of previously issued SBCs. Blue Shield therefore does not intend to issue revised SBCs for current plan years to address COVID-19 related coverage changes. For SBCs provided for future plan years, Blue Shield will incorporate information regarding any applicable COVID-19 related coverage changes, consistent with the requirements of the SBC rules.

Administrative Services Only (ASO) and Shared Advantage

1. **How is Blue Shield of California applying the Federal mandate to waive cost-shares for COVID-19 testing to Self-funded business?**
For self-funded business, Blue Shield will apply the Federal mandate by administering benefits for COVID-19 testing, screening, and related services without any co-payment, coinsurance, or deductible requirements, prior authorization or other medical management requirements. Services received in-network will be covered with zero-member cost share. For out-of-network services co-payment, coinsurance, and deductible requirements will be waived and the out-of-network provider will be paid the allowed amount. If members are balance billed, they should follow Blue Shield's standard procedure for appeals and grievances.

2. **Is Blue Shield enforcing active-at-work and minimum work hours for self-funded groups?**
Self-funded groups/Plan sponsors typically determine Eligibility and Continuation of Group Coverage which should be described in the plan document. If the plan document does not detail furlough or reductions-in-force situations, ultimately, it is up to the plan sponsor to determine how to proceed with employees in these situations.

3. **What is the rate/claims implications of decisions regarding paid/unpaid leave, shared work, partial work, reduced hours and furloughs?**
Effective through May 31, 2020, Blue Shield will not make off-anniversary changes to stop loss premiums due to change in employee work status.
If an employer/plan sponsor elects to lay off/furlough employees but continue to pay stop loss premiums as if they were active, we will continue coverage.

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4. **How will COVID-19 testing affect my stop loss coverage through Blue Shield Life?**
COVID-19 is treated like any other illness under our standard stop loss policy. For plans with Blue Shield Life stop loss, Blue Shield Life will not require plan document changes to incorporate the COVID-19 benefit changes listed below and will accept the related charges as "covered expenses" under the stop loss policy without requiring mid-year changes to the current policy's aggregate factors and/or premiums.
We will waive deductible and/or out-of-pocket charges for:
    - COVID-19 testing and screening
    - COVID-19 treatment
    - Telemedicine or virtual doctor visits
    - Waiving prior-authorization requirements on diagnostic testing or treatment of COVID-19 that may have otherwise applied
    - Paying for out-of-network COVID-19 testing as required under applicable law.
    - Allowing early refills of prescription medications

5. **What will be the process for accepting plan changes that may eliminate member cost sharing for the above?**
Blue Shield is implementing plan changes, including cost-sharing waivers, to address state and federal legal mandates regarding the elimination of prior authorization and co-payments, coinsurance, and deductibles for medically necessary COVID-19 testing and related screening. In addition, Blue Shield is implementing the expanded telemedicine and pharmacy services described above. We have communicated these changes directly to employer groups, and groups are not required to take any additional steps related to the acceptance of these changes. Groups that want to make other types of plan changes should contact their account team.

6. **Will these services above accumulate towards the stop loss coverage?**
Yes.

7. **If I have a Blue Shield Life stop loss policy, will early refills claims accumulate towards deductibles for specific and/or aggregate?**
Yes. If your stop loss policy is through Blue Shield Life. Self-funded groups that carve out stop loss should check with their stop loss carrier.

8. **Does your standard contract contain an exclusion or limitation for pandemics?**
No. Our standard stop loss contract does not have an exclusion or limitation for pandemics.

9. **Are you planning any changes to coverage terms, conditions or rates due to COVID-19, either midterm or at renewal, including renewal delay or extension?**
At this point in time, we are monitoring the situation closely and have no plans to delay or extend renewals.

10. **Will Blue Shield Life consider changes in deductibles mid-year for stop loss?**
No.

11. **What is Blue Shield Life's position regarding the stop loss contract, terms, provisions, and rates if there are any temporary (or long term) reductions in the group's enrollees?**
To maintain coverage under the stop loss policy, the employer/plan sponsor would need to continue to pay stop loss premiums for laid off/furlough employees. We would anticipate any furlough/laid off employees to be covered under the plan as an active employee or offered COBRA and the plan sponsor would continue to cover them under stop loss.

12. **How will Active-at-Work provisions impact stop loss through Blue Shield Life?**
For current in-force Blue Shield Life stop loss groups where employer continues to pay premiums for laid off/furlough employees, we will waive the Active at Work provision.

13. **Will there be any delays or changes to the process of stop loss claim reimbursement?**
Blue Shield Life does not see any impact to our process in advance funding for ASO/SA+ groups with Blue Shield Life stop loss.

14. **If clients are changing their leave policies, will Blue Shield Life update contracts to mirror language? Will there be a cost impact? What are your requirements for notification?**
Self-funded groups/Plan sponsors typically determine Eligibility and Continuation of Group Coverage, which should be described in the plan documents. If the plan document does not detail furlough or reductions-in-force situations, ultimately, it is the plan sponsor to determine how to proceed with employees in these situations. Groups with Blue Shield Life stop loss would need to notify us of the proposed change in leave policy. If approved, no update to stop loss contract would be required, but we would document the decision to allow for the updated leave policy.

15. **Will there be an introduction of, or change to, a minimum premium or floor?**
For ISL, Blue Shield does not have a minimum premium or floor. Please note there is a +/- 15% change in enrollment provision. Effective through May 31, 2020, Blue Shield will not make off-anniversary changes to stop loss premiums due to enrollment drops. For ASL, a minimum annual aggregate deductible continues as per stop loss policy.

16. **For self-funded groups with stop loss coverage from Blue Shield Life that are electing to provide special open enrollment under new federal guidelines, what does the plan sponsor need to provide Blue Shield?**
    1. Plan amendment and terms/conditions of the special enrollment period, including effective date
    2. An updated census outlining the new enrollees, term enrollees, and any enrollee changes (movement to new plan or plan tier)
    3. Completed health questionnaire for each new enrollee

    Blue Shield Life reserves the right to rerate, apply lasers, or add aggregating specific corridors depending on the information provided above. Enrollees without a completed questionnaire will not be covered by the stop loss policy. All changes must be consistent with the applicable IRS guidance and other law and applied in a nondiscriminatory manner.

ASO: Telemedicine

1. **How will Teladoc claims be processed for COVID-19?**
Blue Shield is covering all Teladoc visits (with no cost to the group or the member) from March 17 through May 31, 2020 for groups that offer Teladoc. During this period, claims for Teladoc services will not be invoiced back to self-funded groups and, therefore, will not accrue toward stop loss deductibles for self-funded groups that have Blue Shield stop loss. Under Blue Shield's standard stop loss contract, covered telemedicine services would accrue toward the claim liability for the specific and aggregate deductible.

2. **If a self-funded employer currently has not purchased Teladoc but wants to add Teladoc, off anniversary, will Blue Shield allow a mid-year change?**

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Yes. Blue Shield will allow the addition of Teladoc off anniversary assuming the service is offered until the end of the current policy period. Please check with your account team to initiate the addition of Teladoc.

3. **Will Blue Shield continue to cover Teladoc COVID-19 services at no member cost share beyond 5/31/20?**
No. Blue Shield is not extending coverage of Teladoc's medical and behavioral health services without cost sharing for self-funded groups beyond May 31, 2020. Groups wanting to maintain the same level of coverage extended to them by Blue Shield in response to COVID-19 can do so at their own expense and should work with their Blue Shield account manager.

Payments and finances

1. **What are Blue Shield's policies for termination of benefits on delinquent payments? Will you consider a flexible payment schedule, such as an extended grace period for those who may be struggling due to COVID-19?**
For customers who are having difficulty paying their monthly premiums, the company is offering a variety of ways to help. Blue Shield introduced a flexible payment program for the Individual and Family Plan and Medicare Supplement plan members, and Small Business groups. These members and groups may use the flexible payment program for up to two months during the months of April, May, June, July, August, and September 2020. Details of this program are available here.

2. **How is Blue Shield is working with providers to let members know their cost sharing is waived? Will members be reimbursed if they are incorrectly charged?**
Blue Shield is taking steps to keep providers informed about cost sharing changes related to COVID-19. In addition, our Appeals and Grievance teams are included in the implementation of these new regulatory requirements and will be able to assist members in resolving any incorrect cost-sharing charges.

3. **What is the estimated cost for COVID-19 testing?**
Blue Shield is estimating that the average test cost is $60 based on announced payment policy for Medicare.

4. **Does Blue Shield anticipate any pharmacy price impacts?**
There are many factors that influence the price of drugs and our pharmacy benefits. Drug shortages due to disruption to the supply chain and increased utilization of prescription medications to treat COVID-19 symptoms could increase our costs. The pharmacy team works with the actuary team to model out potential impacts to pharmacy pricing.

5. **Will Blue Shield be holding rates at the same level as current – how will this we be handled at the renewal?**
The impact to rates for testing and treatment of COVID-19 will depend on a group's utilization.

6. **With the ability to rerate based upon changes in enrollment, will Blue Shield deploy rerate strategies midyear?**
Effective through May 31, 2020, rates within a policy year will not change due to COVID-19-related reductions in enrollment.

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7. **Has Blue Shield made any assumptions around COBRA participation volumes? If yes, what is the anticipated impact on the rates?**
   At this time, it is too early to estimate impacts related to an increase in COBRA, however, at the time of renewal rate setting, COBRA percentage will be considered when setting rates.
8. **If Blue Shield has released a renewal, will those rate actions hold, or is there a potential for adjustments?**
   Blue Shield is honoring any released renewal positions assuming the group has not made any changes to their covered population or plans outside of temporary shifts in enrollment due to COVID-19 or approved COVID-19 related cost sharing changes.

9. **How will COVID-19 impact our rates?**
   We are monitoring the situation to understand the impact of COVID-19 on future medical costs and will take each situation on a case-by-case basis.

10. **How are Blue Shield and Blue Shield Promise responding to Insurance Commissioner Ricardo Lara's request for insurers to extend their grace periods for payment of premium?**
    Blue Shield and Blue Shield Promise are supporting our customers who have been impacted financially due to COVID-19 by introducing premium payment options to help ensure coverage through this health and economic emergency. For clients who are having difficulty paying their monthly premiums, we are offering a variety of ways to help. Blue Shield introduced a premium payment program in April for IFP, Medicare Supplemental plan members, and small business groups. Details of the program are available here.

    This program is not related to the California insurance commissioner's request for extended grace periods, and is available for IFP, Medicare, and small group customers only. Large group clients should contact their Blue Shield representative with inquiries regarding premiums and payments.

11. **Is Blue Shield offering premium credits to employer groups and individual & family plans?**
    Blue Shield is applying a one-time premium credit to the following market segments for the November or December* billing cycle:

    - Medicare Supplement medical, dental, and/or vision plan subscribers
    - IFP dental plan and/or vision plan subscribers (not IFP medical plans)
    - Fully insured group medical, dental and/or vision plan employers (Flex-funded excluded)

    Blue Shield will apply a 10% credit on medical premiums and a 30% credit on dental and/or vision premiums for all customers eligible to receive premium credits through this program. The premium credit is based on the October premium for the medical, dental, and/or vision plan(s) and does not include any pass through charges.

    There may be some variance in the exact percentages, resulting from plan changes or enrollment changes. The credit will be shown on customers' November billing statement (CCSB in December*). Customers receiving the credit are not obligated to continue their coverage with Blue Shield, and no repayment will be required of customers discontinuing coverage at any time.

    The Premium Assistance Program and Premium Payment Plan Program have concluded. Enrollment in either of these programs does not impact this new Premium Credit Program.

*Blue Shield On-exchange small groups (CCSB) will have premium credits applied through this program for their December billing cycle. All other market segments included in the program will have credits applied for November billing cycle.

Online resources

Blue Shield resource sites

- Member COVID-19 resource page
- Employer and Broker COVID-19 resource page
- Blue Shield News Center

Government resource sites

- California testing task force
- Paycheck Protection Program for Small Businesses
- Keeping American Workers Paid and Employer Act
- CDC Resources for Businesses and Employers
- CDC Coronavirus updates page
- California Department of Insurance (CDI) Bulletin re: COVID-19 Screening and Testing
- Department of Managed Health Care (DMHC) Letter re: COVID-19 Waiver of Cost Share
- DMHC COVID-19 Response

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