National General Benefits Solutions

COVID-19 FAQ – Updated March 27, 2020

At National General Benefits Solutions, we continue to monitor the COVID-19 outbreak and provide you with updates as they are available. Know that the health and well-being of you, your employees and your families remains our top priority.

This update includes:

COVID-19 Related Plan Enhancements

To help limit the spread of COVID-19, National General has made the following benefit enhancements to all plans effective immediately.*

Telehealth services conducted by a health care provider.

- All claims submitted with the place-of-service code "02" (telehealth) will be considered according to the plan benefits.
- Any claim with the place-of-service code "02" (telehealth) that is related to diagnostic testing for COVID-19 will have all member cost sharing waived. Your Plan members will not be subject to deductibles, copays, or coinsurance for telehealth virtual visits that are part of diagnostic testing for COVID-19.
    - For Members who obtain telehealth virtual visits for diagnostic testing of COVID-19 from in-network providers, the Plan will pay 100% of the network-contracted rate.
    - For Members who obtain telehealth virtual visits for diagnostic testing of COVID-19 from a non-network provider, and for members covered by plans that do not use provider networks, the Plan will pay 100% of the Maximum Allowable Amount, per the terms of your Summary Plan Description. Any balance billing for such testing charges will be eligible for additional Plan consideration by contacting the Customer Service team at the phone number on the back of the Member's Medical Plan ID card.
- Members should visit their provider's website or call their office to inquire about whether the healthcare provider offers virtual visits.

Plans with Teladoc.

- If your Plan includes Teladoc for your members and has a consultation fee, any applicable Teladoc consultation fees will be waived for the member. Your Plan members will not have to pay a consultation fee for Teladoc services. The consultation fee will be submitted as a fee to the Plan (payable from the claims account).
- The waiver of the Teladoc member cost sharing is in effect through the end of June 2020.

Waived member cost sharing for COVID-19 diagnostic tests and related charges.

- Your Plan members will not be subject to deductibles, copays, or coinsurance for diagnostic testing charges related to COVID-19. This means 100%, first-dollar Plan payment for professional services, lab tests, and facility charges (e.g. office visit, ER visit, urgent care visit) incurred for a COVID-19 diagnostic test.
    - For Members who obtain COVID-19 diagnostic tests from in-network providers, the Plan will pay 100% of the network-contracted rate.
    - For Members who obtain COVID-19 diagnostic tests from a non-network provider, and for members covered by plans that do not use provider networks, the Plan will pay 100% of the Maximum Allowable Amount, per the terms of your Summary Plan Description. Any balance billing for such diagnostic test charges will be eligible for additional Plan consideration by contacting the Customer Service team at the phone number on the back of the Member's Medical Plan ID card.
    - If a Member tests positive for COVID-19, all additional services provided to the Member for the treatment of and medically necessary supportive care for COVID-19 will be subject to the Member's deductible, copays, and coinsurance.

Waived Penalty for Emergency Room COVID-19 diagnostic tests.

- Since some members seeking COVID-19 diagnostic tests may be directed to an emergency room for quarantine purposes, the standard penalty for emergency room use for non-emergencies will NOT be applied for COVID-19 diagnostic tests.

Waived Prior Authorization requirements/penalties for COVID-19 testing and treatment.

- There will be no prior authorization requirements for plan members seeking COVID-19 diagnostic tests, treatment for COVID-19, or medically necessary supportive care if tested positive for COVID-19.

Outpatient Prescription Drug Support.

- Early refills and prescriptions for up to 90-day supplies (as prescribed) will be permitted upon request due to quarantine or other COVID-19 hardships.

For inquiries and benefit questions, members should call the customer service number on the back of their Medical Plan ID card.

Members concerned about exposure to COVID-19 should contact their health care provider or state health department. National General's customer service call center will be available to assist if customers have any questions about coverage for COVID-19 testing-related services, members should call the number on the back of their Medical ID cards.

* If you do not want to apply these benefit enhancements to your group health plan, please contact your National General Benefits Solutions Account Manager.

Plan Administrative FAQs:

To help you navigate through options for your self-funded health plan, we have prepared the following administrative Frequently Asked Questions list. Please note, since COVID-19 related emergency regulations and treatment landscapes are changing rapidly, the answers below are subject to change, and we will continue to provide updated guidance as necessary.

1. **During this time, will there be any additional grace period applied to billing?**

    - National General will ensure that all state-specific regulatory requirements are followed, as applicable. In general, you have a 30-day grace period. During the grace period, claims will pend until payment is received. Your Plan can be reinstated up to 60 days after the date of non-payment (lapse). If this happens, you should call the National General Benefits Solutions Account Management team to request reinstatement.

2. **Can I self-adjust my monthly payments?**

    - Employers should avoid adjusting their regular monthly payment to ensure claims continue to be paid. Resources to assist small businesses during this time may be available through the U.S. Small Business Administration (SBA) or government agencies in your state.

3. **Can I request a mid-year plan change (buy-down) to reduce monthly cost?**

    - We may consider mid-year plan design changes to reduce your monthly cost, once per plan year, however, employers are required to give a 60-day material modification notice to plan members advising of any plan changes before they become effective. If you are considering this change, please contact your Account Manager to discuss your options.

4. **If I have to lay off employees who thereby lose coverage, but later rehire those employees, can employment waiting periods be waived?**

    - Upon request, you may waive the waiting period for any previously employed and previously covered employees should they return to work within 90 days of the termination. The waiting period waiver must be applied uniformly to all previously covered employees who have been rehired.

5. **Will actively-at-work requirements be enforced?**

    - During the Emergency Period (currently determined as running through May 31, 2020) National General Benefits Solutions will not enforce actively-at-work requirements on current plan participants (actively enrolled in coverage), if the employer desires to lessen these restrictions. Monthly plan cost (premium equivalent) must continue to be paid and employer contribution must be maintained.

6. **What if I want to continue offering coverage but my enrolled employees no longer meet the minimum hourly requirement?**

    - During the Emergency Period (currently determined as running through May 31, 2020) National General Benefits Solutions will waive or reduce the minimum hourly requirement for currently covered employees if the employer desires to make such a change to its eligibility criteria. Any such waiver or change will only apply to enrolled employees who were previously considered eligible for coverage under the prior (standard) minimum hourly requirement. The standard eligibility hourly requirements will apply to all employees who were not previously covered. All other eligibility and payment requirements will still apply.

7. **Will you make exceptions for Employer contributions?**

    - The minimum employer contribution requirement is 50%. It is the responsibility of the employer to ensure that the full monthly payment is collected and paid within a timely manner.

8. **If my plan no longer has any enrollees, can I suspend the plan and restart with the same population at a later date without new underwriting and new applications?**

    - No, if you no longer have any active members on the plan, the plan will need to be terminated. The termination of the plan will trigger a Qualifying Life Event for the members to seek coverage during a Special Enrollment Period, pursuant to the Affordable Care Act. In addition, members may potentially be eligible for a subsidy, or to purchase a short term medical policy. We will not allow reinstatement of a terminated plan, except as provided in response to Question 1 above.

9. **Can the Open Enrollment Period be extended when my Plan is up for reissue to a subsequent plan year?**

    - National General Benefits Solutions understands COVID-19 related complications can impact enrollment timelines. Please work with your Account Manager to review available options and flexibility.

10. **How will COBRA premium be handled?**

    - COBRA premium will be administered pursuant to the standard process. The additional fee associated with COBRA administration (2% of premium equivalent) applies. Employees who have elected COBRA will continue to be invoiced for the payment directly. Payment will not be accepted by the employer.

11. **Can employers with fewer than 20 employees offer COBRA if they haven't elected to do so?**

    - The Plan's original COBRA election (or waiver) will remain in force. However, employers are encouraged to remind their employees who are losing coverage to review the Affordable Care Act options through the exchange (and their eligibility for potential subsidies) based on the loss of coverage Qualifying Life Event.

General COVID-19 FAQs

Who should be tested for COVID-19?

As of March 8, 2020, the Centers for Disease Control (CDC) recommends that anyone with symptoms of COVID-19, returning from a CDC-designated "Level 2" or "Level 3" advisory area, or who has been in contact with someone who is suspected or confirmed of having the coronavirus within the last 14 days, should be tested.

Any individual who suspects that they may have been exposed to the coronavirus or is exhibiting symptoms should consult with their health care provider to make the appropriate testing recommendation, in line with CDC guidelines.

Can anyone get tested for COVID-19?

The CDC has outlined clinical criteria to qualify as a candidate that may be approved by a doctor. The CDC clinical criteria for a COVID-19 person under investigation (PUI) have been developed based on what is known about COVID-19 and are subject to change as additional information becomes available.

How can members access COVID-19 testing?

Members who have concerns that they may have been exposed to COVID-19 or may have symptoms of COVID-19 should contact their health care practitioner or state Department of Health for testing.

Is there a vaccine or treatment available?

No vaccine or specific treatment for COVID-19 is available at this time; care for a person who tests positive for the virus is supportive in nature.

How can I learn more about COVID-19?

Here are some resources to learn more about COVID-19:

- https://www.cdc.gov/coronavirus/2019-ncov/index.html
- https://www.who.int/emergencies/diseases/novel-coronavirus-2019
- https://www.cdc.gov/coronavirus/2019-ncov/about/steps-when-sick.html

What will a plan members' out-of-pocket costs be for COVID-19 diagnostic testing?

Cost sharing will be waived for COVID-19 diagnostic testing-related services. This means the member will not be subject to deductibles, copays, or coinsurance.

What if a plan member receives a bill for COVID-19 diagnostic testing?

In that event, National General Benefits Solutions Self-Funded Program members should call the number on the back of their Medical ID card.

We're here for you!

Our teams are here to help when you need it. We are available to provide options and information for you.

- If you're a current client, please contact the Account Management team at 888-659-1859 or email ngbsselffunded@ngic.com.
- If you're and agent with new business, please contact our Sales team at 877-225-5077.