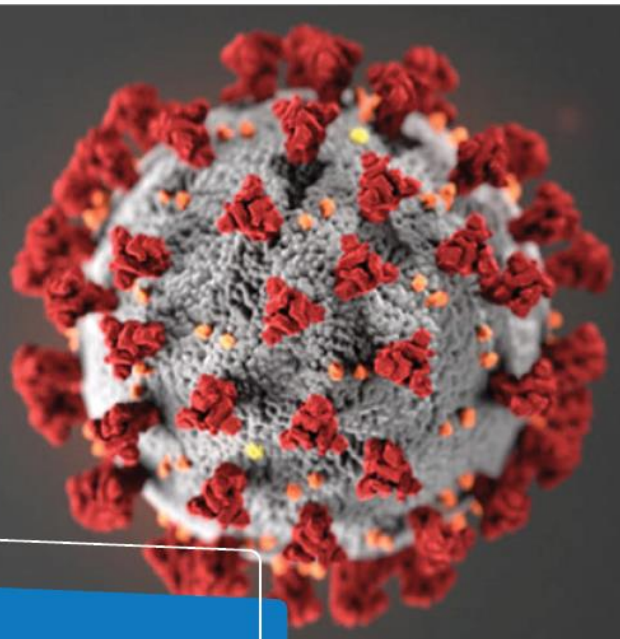
Anthem



Coronavirus (COVID-19)

FREQUENTLY ASKED QUESTIONS

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

December 9, 2021

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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? 10/8/21
People with COVID-19 have had a wide range of reported symptoms – ranging from mild symptoms to severe illness including hospitalization and death.

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 Anthem 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? 5/24/21
The best way to prevent infection is to become vaccinated and avoid being exposed to the virus that causes COVID-19. The guidance on protecting yourself is different for those who are vaccinated and those who are not vaccinated.

Get vaccinated

- Learn about the benefit of vaccines**.**
- Learn how to find a vaccine near you.
- Learn how to resume activities safely after you've been fully vaccinated.

For unvaccinated people, prevent getting sick

- Avoid crowds and poorly ventilated indoor spaces.
- Avoid close contact with people who are sick.
- Quarantine if you believe you've been exposed to the virus or if you are sick.
- Wear a mask that covers your nose and mouth to help protect yourself and others.
- Put social distance between yourself and other people who don't live with you. Keeping distance from others is especially important for people who are at higher risk of getting very sick.
- Wash your hands often with soap and water. Use hand sanitizer if soap and water aren't available.
- People living in close quarters or shared housing should take additional precautions.
- Improve ventilation in your home. The main way COVID-19 can spread is through droplets and particles that can be breathed in by other people or land on their eyes, noses, or mouth.

Do I need to wear a mask? 5/24/21

It's best to follow the CDC's recommendations on how to protect yourself, including who should wear masks 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? 10/8/21

Casirivimab and Imdevimab

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Regeneron. Coverage will be made available based on the EUA indication and in accordance with FDA guidance.

The FDA EUA indicates casirivimab and imdevimab can be used in adults and pediatric patients age 12 and older weighing at least 88 pounds (40 kg):

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- for post-exposure prevention of COVID-19 in persons who are:

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- are not expected to build up enough of an immune response to the complete COVID-19 vaccination (for example, someone with immunocompromising conditions, including someone who is taking immunosuppressive medications),

and

- have been exposed to someone who is infected with SARS-CoV-2. Close contact with someone who is infected with SARS-CoV-2 is defined as being within 6 feet for a total of 15 minutes or more, providing care at home to someone who is sick, having direct physical contact with the person (hugging or kissing, for example), sharing eating or drinking utensils, or being exposed to respiratory droplets from an infected person (sneezing or coughing, for example).

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- someone who is at high risk of being exposed to someone who is infected with SARS-CoV-2 because of occurrence of SARS-CoV-2 infection in other

individuals in the same institutional setting (for example, as nursing homes, prisons).

Distribution will be controlled by federal government, which will collaborate with local and state governments.

Anthem is waiving cost-sharing for the treatment of COVID-19 by in-network providers from April 1 through Jan. 31, 2021 for members of its fully-insured employer, Individual and Medicaid plans. Cost-sharing for members with Medicare Advantage and Medicare GRS plans is waived until Feb. 28, 2021.

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At this time, the federal government covers the cost of bamlanivimab and etesvimab. The U.S. government has committed that patients will have no out-of-pocket costs for bamlanivimab and etesevimab, although healthcare facilities may charge a fee to administer the antibody therapy. When an administration fee is charged for a therapy covered by an EUA, Anthem will cover the costs of administration from in-network providers under the member's medical benefit.

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Veklury/remdesivir

On Oct. 1, 2020, the Food & Drug Administration approved Veklury, or remdesivir, as the first drug to treat COVID-19 for use in adults and patients older than 12 who require hospitalization.

Anthem does provide coverage for remdesivir, which is currently only administered in the hospital or similar healthcare setting capable of providing acute care. Anthem is waiving cost-sharing for the treatment of COVID-19 by in-network providers from April 1 through Jan. 31, 2021 for members of its fully-insured employer, Individual and Medicaid plans. Cost-sharing for members with Medicare Advantage and Medicare GRS plans is waived until Feb. 28, 2021.

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Other non-FDA-approved drugs in treatment of COVID-19

Several other FDA-approved drugs not indicated for the treatment of COVID-19 but recommended in the NIH guidelines include dexamethasone (other corticosteroids prednisone, methylprednisolone, or hydrocortisone may be used if dexamethasone is not available), baricitinib, tofacitinib, tocilizumab, and sarlimumab.

Dexamethasone

- Dexamethasone, a steroid treatment available for more than 50 years, has not been approved by the FDA to treat COVID-19. Dexamethasone will be covered by Anthem based on the results of the RECOVERY study and National Institutes of Health recommendations for use in hospitalized patients. The recently announced preliminary findings of the UK-based *Randomised Evaluation of COVID-19 Therapy* (RECOVERY) study showed that dexamethasone may result in one life saved in every eight patients treated on ventilators and one life saved in every 25 patents treated using oxygen alone. Based on the RECOVERY trial, the COVID-19 Treatment Guidelines Panel of the National Institutes of Health issued the following recommendations on the use of dexamethasone for COVID-19 The panel recommends using dexamethasone (at a dose of 6 mg per day for up to 10 days) in patients with COVID-19 who are mechanically ventilated and in patients with COVID-19 who require supplemental oxygen but who are not mechanically ventilated.
- The panel recommends against using dexamethasone in patients with COVID-19 who do not require supplemental oxygen.
- While these preliminary results are a promising, more research is needed to confirm these findings.

We will monitor the drug supply.

Baracitinib was granted an Emergency Use Authorization for treatment of COVID-19 in hospitalized adults and pediatric patients 2 years of age or older requiring supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO).

Tocilizumab was granted an Emergency Use Authorization for EUA for the emergency use for the treatment of COVID-19 in hospitalized adults and pediatric patients (2 years of age and older) who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation.

Hydroxychloroquine and chloroquine

On June 15, 2020, the FDA removed Emergency Use Authorization for the anti-malaria drugs chloroquine and hydroxychloroquine. The EUA had allowed the drugs to be used for the treatment of COVID-19 for those patients meeting specific clinical criteria. We are monitoring developments in this area closely and will evaluate coverage of any treatments once approved.

Ivermectin

Ivermectin tablets are FDA-approved at very specific doses to treat some parasitic worms, and there are topical (on the skin) formulations for head lice and skin conditions like rosacea. The FDA has received reports of individuals using the oral tablets for humans and other forms used in animals to prevent or treat COVID-19 infection. Data are insufficient to determine if ivermectin safe or effective for treatment or prevention of COVID-19 infection. We are monitoring developments in this area closely and will evaluate coverage of any treatments once approved.

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 Anthem waiving member cost share for diagnostic tests, visits and treatments related to COVID-19? 8/13/21
Anthem is committed to help our members gain timely access to care and services and are actively monitoring developments with the pandemic and possible extensions of decisions previously made by Anthem. Our actions should help reduce barriers to seeing a doctor, getting tested and receiving treatment. Anthem is waiving:

- cost-sharing for the treatment of COVID-19 by in-network providers from April 1 through Jan. 31, 2021 for members of its fully-insured employer, Individual and Medicaid plans. Cost-sharing for members with Medicare

Advantage and Medicare GRS plans is waived until Feb. 28, 2021. 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 as deemed medically necessary by a health care clinician who has made an assessment of a patient, including serology or antibody tests, for members of our employer-sponsored, Individual, Medicare and Medicaid plans. Recent federal guidance clarifies that a health care provider need not be "directly" responsible for providing care to the patient to be considered a qualifying clinician, as long as the clinician makes an individualized clinical assessment to determine whether the test is medically appropriate for the individual in accordance with current accepted standards of medical practice. 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, including telehealth visits, beginning March 18, 2020 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 for COVID-19 treatment from March 17 through Jan. 31, 2021 for our fully-insured employer, individual plans, and where permissible, Medicaid plans. Medicare Advantage and Medicare GRS plans are waived through Feb. 28, 2021. Self-funded plans that had already chosen to opt-in could continue to do so through Jan. 31, 2021.
- cost sharing for non-COVID-19 related telehealth services from Anthem's telehealth provider LiveHealth Online from March 17, 2020 through May 31, 2021 for our fully-insured employer, individual, and where permissible, Medicaid plans. Medicare Advantage members pay no member cost share for LiveHealth Online, regardless of national emergency.

- cost-sharing for telehealth visits from in-network primary care providers during 2021, including visits for mental health or substance use disorders, for Medicare Advantage.
- cost-sharing for telehealth visits for in-network providers for **non-COVID-19** services for Medicaid continue without cost share as usual, where permitted.
- cost-sharing for audio-only, in-network provider telephonic only visits through Dec. 31, 2021 for fully-insured employer-sponsored, individual, Medicare and Medicaid plans. Self-funded plans that have already chosen to opt-in may continue to do so through Dec. 31, 2021.
- cost-sharing for audio-only, in-network provider telephonic only visits through December 31, 2021 for Medicare Advantage plans.
- cost-sharing and coverage for COVID-19 vaccines and their administration for all members in-network or out-of-network within 15 days of their recommendation by either the Advisory Committee on Immunization Practices of the Centers for Disease Control or the U.S. Preventive Services Task Force.

The cost-sharing waivers noted above includes co-pays, 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.

How are COVID-19 coverage and cost share waivers different for members depending on whether they have Medicare Advantage or Medicare Supplement?

There are two key differences. Unlike Medicare Advantage, cost shares for in person visits and services to treat COVID-19 are not waived for Medicare Supplement. However, both waive cost shares for telehealth visits from March 17 through Dec. 31, 2020. Medicare Advantage waives cost shares for telehealth visits from in-network providers. Medicare Supplement waives costs shares for all telehealth visits, including telehealth treatment of COVID, from any provider that accepts Medicare.

For what kind of COVID-19 treatments will member cost shares be waived?
For Anthem'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?
Anthem's waiver of member cost share associated with COVID-19 treatment would apply to FDA-approved medications or vaccines within 15 days of their recommendation by either the Advisory Committee on Immunization Practices of the Centers for Disease Control or the U.S. Preventive Services Task Force.

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Is Anthem covering COVID-19 treatment for in-network and out-of-network providers? 2/8/2021

From April 1, 2020 through Jan. 31, 2021, Anthem will waive member cost shares for treatment from in-network providers, for our fully-insured employer plans, individual plans, and Medicaid plans, where permissible. Cost-sharing for members with Medicare Advantage and Medicare GRS plans is waived until Feb. 28, 2021.

For out-of-network providers, Anthem is waived cost shares from April 1, 2020 through May 31, 2020.

Has Anthem changed claims processing for cost share waivers for COVID-19 related services?
Anthem continues to waive member cost-sharing for COVID-19 testing and COVID-19 testing related services as required by the federal mandate. Early in the pandemic, billing codes specific to COVID-19 were not available. Effective June 1, 2020, Anthem updated operational procedures to align with the newest COVID-specific code set published by CMS. To waive member cost-sharing for COVID-19 testing and COVID-19 testing related services, the provider must submit claims appending modifier CS to procedure codes and/or use diagnosis code U07.1 when appropriate to indicate the services were related to COVID-19 testing.

Is Anthem providing Medicare members with post-discharge support?
Anthem 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. Anthem's care managers can help provide coordination of medications and home health needs, scheduling follow up appointments and transportation and, arranging for post-discharge meal delivery.

How is Anthem covering telehealth? 7/14/21
Telehealth (video and audio)
Telehealth services are available from Anthem's authorized telehealth service, LiveHealth Online, as well as other network providers who deliver virtual care through internet video and audio services.

For non-COVID-19 related telehealth services from Anthem's telehealth provider, LiveHealth Online, cost sharing will be waived from March 17, 2020 through July

31, 2021, for our fully-insured employer, individual, and where permissible, Medicaid plans. Medicare Advantage members pay no member cost share for LiveHealth Online, regardless of national emergency.

After Oct. 1, 2020, telehealth cost shares for individual, employer-sponsored and Group Retiree Solutions, will no longer be waived for non-COVID-19 services.

Waivers are in place for:

- cost-sharing for telehealth visits from in-network providers for COVID-19 treatment from March 17 through Jan, 31, 2021 for our fully-insured employer, individual, and where permissible, Medicaid plans. Medicare Advantage and Medicare GRS plans are waived through Feb. 28, 2021. Self-funded plans that had already chosen to opt-in could continue to do so through Jan. 31, 2021.
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- cost-sharing for audio-only, in-network provider telephone only visits through July 31, 2021 for fully-insured employer-sponsored, individual and Medicaid plans. Self-funded plans that have already chosen to opt-in may continue to do so through May 31, 2021.
- cost-sharing for audio-only, in-network provider telephonic only visits through December 31, 2021 for Medicare Advantage plans.

The cost-sharing waivers noted above includes co-pays, 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 out-of-network providers, Anthem is waiving cost shares for telehealth from March 17 through June 14, 2020.
Note: Telehealth does not include the use of facsimile, telephone only or email. Most members of Medicare, Group Retiree Solutions, and Medicaid (in states where it is a benefit) normally receive LiveHealth Online visits with no cost share.

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, Anthem 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 Anthem cover that?
Anthem 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?
Anthem 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, Anthem'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.

Medicaid answer only: Anthem is committed to working with and supporting its contracted providers. Our state-mandated 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.

Is Anthem relaxing prior authorization?
From March 26 through December 31, 2020, Anthem will cover respiratory services for acute treatment of COVID-19 and will suspend prior authorization requirements on durable medical equipment and respiratory services critical for the treatment of COVID-19, including oxygen supplies, respiratory devices, continuous positive airway pressure, CPAP devices, non-invasive ventilators, and multi-function ventilators.

From March 1 through May 30, 2020, Anthem is suspending select prior authorization requirements to allow care providers to focus on caring for patients

diagnosed with COVID-19, including suspension of prior authorization requirements for patient transfers, prior authorization requirements for skilled nursing facilities.

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.

Will Anthem provide additional stop loss coverage for claims that are incurred but not paid until after the Eligible Claim Date Period?
Anthem will provide stop loss coverage consistent with existing terms. If a group would like additional claims-run out coverage or, claims run-in coverage when the policy renews, these options are available for purchase.

Vaccine Questions

Current vaccines

Which vaccines are available to help prevent infection and complications from COVID-19?

Johnson & Johnson COVID-19 vaccine

The Johnson & Johnson vaccine can be given as a single dose in people ages 18 and up. It is also recommended as a booster shot for people who had the J&J vaccine already and can serve as a booster shot for people who had their first series with the Moderna or Pfizer vaccines and meet certain criteria.

Primary series
On Feb. 26, 2021, the FDA granted an Emergency Use Authorization for the COVID-19 vaccine produced by Johnson & Johnson for prevention of COVID-19 infection in people 18 years or older. The decision was based on a large clinical trial that showed a single dose of this vaccine significantly reduced the risk of getting moderate to severe symptomatic COVID-19 infection compared to placebo.

The J&J vaccine works well in both older and younger adults but is still being studied in those under age 18. The CDC's website has more information about the Johnson & Johnson COVID-19 vaccine, including information about a very small number of reports of a rare and severe type of blood clot and a neurologic disorder that could happen in people who have received the Johnson & Johnson COVID-19 vaccine. Members who have questions about COVID-19 vaccines should talk to their doctor.

Booster

A single-dose booster of the vaccine is recommended for all adults ages 18 and up who received the J&J vaccine. The booster can be given at least two months after completion of the single-dose primary series. A J&J booster is authorized for people who have had their first series with either the J&J, Moderna or Pfizer vaccines.

Pfizer-BioNTech COVID-19 vaccine

Pfizer-BioNTech's vaccine can be used in people ages 5 and up. The Pfizer booster is authorized for people 18 and older who have had their first series with either the J&J, Moderna or Pfizer vaccines.

Primary Vaccine series

Pfizer-BioNTech's vaccine was FDA approved on Aug. 23, 2021 for ages 16 and up. It is also available under emergency use authorization for those ages 5 and up.

On Dec. 11, 2020, the FDA granted an Emergency Use Authorization for the COVID-19 vaccine produced by Pfizer/BioNTech for prevention of COVID-19 infection in people 16 years or older. The decision was based on a large clinical trial that showed that two doses of this vaccine given 21 days apart significantly reduced the risk of getting mild to severe symptomatic COVID-19 infection compared to placebo. On May 10, 2021, the FDA amended the EUA to include people from ages 12-15 based on supporting clinical trial data and on Oct. 29 the FDA authorized a lower dose of the vaccine for children 5 through 11 as ongoing studies found the vaccine to be safe without serious side effects

Booster

The Food and Drug Administration's authorization and CDC's guidance for use of the Pfizer-BioNTech vaccine makes the following groups eligible for a booster shot at six months or more after their initial series:

- Age 18 and older

Moderna COVID-19 vaccine

Moderna's vaccine can be used in people ages 18 and up. The Moderna booster is authorized for people who meet certain criteria and who have had their first series with the J&J, Moderna or Pfizer vaccines.

Primary Vaccine series

On Dec. 18, 2020, the FDA granted an Emergency Use Authorization for the COVID-19 vaccine produced by Moderna for prevention of COVID-19 infection in people 18 and older. The decision was based on a large clinical trial that showed two doses of this vaccine significantly reduced the risk of getting mild to severe symptomatic COVID-19 infection compared to placebo. The vaccine works well in both older and younger adults but is still being studied in those under age 18.

Booster

The Food and Drug Administration's authorization and CDC's guidance for use of the Moderna booster makes the following groups eligible for a booster shot at six months or more after their initial series:

Age 18 and older

If I am immunocompromised, do I need an additional dose of vaccine if I received the Pfizer or Moderna vaccine?

People with moderately to severely compromised immune systems are especially vulnerable to COVID-19 and may not build the same level of immunity compared to people who are not immunocompromised. The CDC recommends that people who received the Pfizer or Moderna vaccines with moderately to severely compromised immune systems receive an additional dose of mRNA COVID-19 vaccine at least 28 days after a second dose of Pfizer-BioNTech COVID-19 vaccine or Moderna COVID-19 Vaccine. This additional dose is intended to improve immunocompromised people's response to their initial vaccine series.

If I am immunocompromised, do I need an additional dose and a booster shot?
Moderately and severely immunocompromised people older than 18 who completed an mRNA COVID-19 vaccine primary series and received an additional mRNA vaccine dose **may** receive a single COVID-19 booster dose (Pfizer-BioNTech, Moderna or J&J) at least six months after completing their third mRNA vaccine dose. In such situations, people who are moderately and severely immunocompromised may receive a total of four COVID-19 vaccine doses.

Am I eligible for a booster dose of a vaccine?
Booster
The Food and Drug Administration's authorization and CDC's guidance for use of the Pfizer-BioNTech or Moderna vaccine makes the following groups eligible for a booster shot at six months or more after their initial series:

- Age 18 and older

A single-dose booster of the J&J vaccine is recommended for all adults ages 18 and older. The booster can be given at least two months after completion of the single-dose primary series.

Does a member's booster vaccine have to be from the same manufacturer as the first series of shots?
Members eligible for a booster vaccine may choose which vaccine they receive as a booster dose. Some people may have a preference for the vaccine type that they originally received and others may prefer to get a different booster.

What should members do if they believe they have symptoms from the Johnson & Johnson vaccine that may negatively impact their health?
Members who have received the vaccine and develop shortness of breath, chest pain, leg swelling, persistent abdominal pain, severe or persistent headaches or blurred vision or easy bruising or tiny blood spots under the skin beyond the site of injection within one to two weeks should immediately seek healthcare attention.

How is the Janssen/Johnson & Johnson vaccine given and what are the side effects?
The vaccine is given as a single injection. The most common side effects are injection site pain, headaches, fatigue, and muscle pain.

How is the Pfizer-BioNTech vaccine given and what are the side effects?
The vaccine is given in two separate injections approximately 21 days apart. The most common side effects are injection site pain, fever, fatigue, headaches, chills, muscle or joint pain. These side effects may be more pronounced after the second dose and can be treated with medication to reduce the fever or pain if needed.

How is the Moderna vaccine given and what are the side effects?
The vaccine is given in two separate injections approximately 28 days apart. The most common side effects are injection site pain and swelling, fatigue, headache, muscle and joint pain, fever, chills and nausea and vomiting. These side effects may be more pronounced after the second dose and can be treated with medication to reduce the fever or pain if needed.

What is myocarditis, and what are the symptoms?
Myocarditis (inflammation of the heart muscle) and pericarditis (inflammation of the lining outside the heart) have occurred in a few people who have received the Moderna or Pfizer vaccine. In these rare situations, symptoms began within a few days following receipt of the second dose of vaccine. The chance of having this occur is very low. medical attention right away if you have any of the following symptoms after receiving the vaccine:

- Chest pain
- Shortness of breath
- Feelings of having a fast-beating, fluttering, or pounding heart

Will mRNA-based vaccines impact a person's DNA?
No. The CDC explains how mRNA vaccines work and what they do and don't do here. Both Pfizer-BioNTech and Moderna vaccines are messenger RNA, also known as, mRNA, vaccines.

Will those who take the Janssen/Johnson & Johnson, Pfizer-BioNTech COVID-19 or Moderna vaccine actually get COVID-19?
No. The Janssen/Johnson & Johnson, Pfizer-BioNTech and Moderna COVID-19 vaccines do not contain the virus and can't give anyone COVID-19. The CDC has more information here.

What guidance or guidelines exist for vaccines with two doses?
The CDC has provided guidance regarding many aspects of vaccination for COVID-19.

- Go back to the same place the first dose was administered to get the second dose. This helps make sure that both doses of the same vaccine are delivered.
- Make an appointment when possible for the second dose when receiving the first dose.

Can people get the COVID-19 vaccines at the same time or close to when they get other vaccines, such as the flu vaccine?
Yes, the CDC has issued guidance noting that you can receive a COVID-19 vaccine at the same time or close when you get another type of recommended vaccine. Experience with other vaccines has shown that the way our bodies develop protection, known as an immune response, after getting vaccinated and possible side effects of vaccines are generally the same when given alone or with other vaccines.

Finding a vaccine

Can people get vaccinated for COVID-19 in any state or just where they reside?
Each state has different policies about who has access to vaccines in those states. Coverage is not impacted by where members received their COVID-19 vaccine.

How can members find a COVID-19 vaccine in their state?
Members can go to this page on the CDC web site and scroll down to the section to find COVID-19 vaccines near them. Also, this page can help members find pharmacies expected to provide the vaccine.

Who tracks general vaccine distribution by state?
Several sites are currently tracking, including Anthem's C19 Vaccine.

What is C19 Vaccine?
C19 Vaccine is a publicly available dashboard, developed by Anthem as part of the C19 Navigator and C19 Explorer, that provides national and state-level data on COVID-19 vaccine distribution, administration and allocation. C19 aggregates vaccine-related data daily from top public sources, such as the CDC, US Bureau of Labor and Statistics, the US Census Bureau, the USDA, USAFacts.org, and the Kaiser Family Foundation, and other private and proprietary data sources.

C19 Vaccine offers the following data:

- Status of vaccine administration by state in heat map format
- Vaccine allocation and distribution data by manufacturer, including total vaccine doses distributed and vaccines administered
- Segmented population by vaccination priority
- Percent of population vaccinated nationally and by state
- Vaccine candidate data, including trial status, number of doses required, and federal government purchase agreements

Where can I find out more about the vaccine and its availability?
Members can activate their online account, via their health plan app or their member website, to get updates on COVID-19 vaccines.

Members with Medicare, individual or employer-sponsored benefits, can go into their app, Sydney Health, to register. Members can download the Sydney Health app on Android or iOS.

Medicaid members can log into the website listed on their ID card, or they can download their health plan app from Google Play or the App Store.

When will COVID-19 vaccines be available for children? 11/9/2021
Pfizer-BioNTech's vaccine has been FDA approved for children 5 and up, with children 5-11 receiving a lower dose of the vaccine.
Trials for vaccines from other manufacturers in younger children are ongoing.
Children don't typically get vaccines until they are tested in children, FDA

approved or authorized, and recommended by the CDC for their age group. The CDC lists authorized age groups for vaccines here.

Can pregnant or breastfeeding individuals receive the COVID-19 vaccine?
Yes, pregnant or breastfeeding individuals can be given the vaccine. Additional guidance is provided by the CDC and the American College of Obstetrics and Gynecology.

Which retail pharmacies will have access to the vaccines?
Here is a link to the retail pharmacies that have partnered with the federal government to provide access to vaccines when they become available. Scroll down for state specifics. The list includes pharmacies across the nation, with approximately 60 percent of all US pharmacies participating in the federal program. States may also include additional locations for more pharmacies, as well as other vaccination locations, on their sites accessible via this page.

Vaccine costs and coverage

Will members have to pay for the vaccine?
No. Under the CARES Act, there will be $0 member cost share for the vaccine and its administration during the national public health emergency regardless of whether members get the vaccine from an in-network or out-of-network provider. This applies to all members of Anthem's health insurance plans and most self-insured plans.

When the FDA has fully approved the COVID-19 vaccines, does that change how the vaccine is covered?
No, the COVID-19 vaccines will continue to be covered as they have been. Members pay no cost both for the ingredient and the administration for the COVID-19 vaccine, according to the CARES Act. This applies to all members of Anthem's health insurance plans and most self-insured plans.

Are additional COVID-19 vaccines for members who are immunocompromised covered? Is it the same for all members – individual, employer-sponsored, Medicaid and Medicare?

Yes, members who are immunocompromised pay no cost both for the ingredient and the administration for an additional COVID-19 dose, according to the CARES Act. This applies to all members of Anthem's health insurance plans and most self-insured plans.

Are additional COVID-19 vaccine booster shots covered? Is it the same for all members – individual, employer-sponsored, Medicaid and Medicare?
Following FDA and ACIP approvals, members would pay no cost both for the ingredient and the administration for an additional COVID-19 vaccine booster dose, according to the CARES Act. This applies to all members of Anthem's health insurance plans and most self-insured plans.

Are COVID-19 vaccines covered under the medical or pharmacy benefit?
Anthem health plans cover the COVID-19 vaccine under the medical or pharmacy benefit, depending on the site of administration. If the vaccine is administered by a pharmacy, it will be covered under the pharmacy benefit. If the vaccine is administered at a doctor's office or another clinical site of care, it will be covered under the medical benefit.

Do grandmothered and grandfathered plans need to cover and cost-shares waived for COVID-19 vaccines?
All grandmothered plans are required to cover COVID-19 vaccines, according to the Cares Act. However, all Anthem members with grandfathered plans will also be covered and cost-shares waived.

Will Anthem waive cost shares on treatments for potential complications from a COVID-19 vaccine?
No, Anthem will not waive cost shares on treatments for potential complications from a COVID-19 vaccine.

Can Anthem self-insured customers opt out of COVID-19 vaccine coverage?
No, both fully insured and self-insured plans are required under the CARES Act to cover the COVID-19 vaccine with no member cost sharing for the duration of the public health emergency.

Will the federal government be paying for the cost of the COVID-19 vaccines and their administration?
At least in the short term, the cost of the vaccines, and ancillary supplies will be funded by HHS. The CDC has indicated the vaccine purchased with US taxpayers' dollars will be available at no cost.

CMS, along with the Departments of Labor and the Treasury, require that fully-insured and self-funded plans cover the vaccine and vaccine administration with no member cost-sharing for the duration of the public health emergency.

HHS does not cover the costs of vaccine administration for commercial or Medicaid members but they will cover administration for Medicare beneficiaries, including Medicare Advantage members. Anthem health plans will cover those costs for fully-insured, employer-sponsored customers and many Medicaid members unless otherwise directed by a state. Self-insured customers will be financially responsible for the administration fees.

Vaccine safety

How do I know the new COVID-19 vaccines are safe once available?
Government and private companies are working together to develop safe and effective vaccines. Researchers are using past research on similar viruses and combining resources to reduce the time it historically has taken to research, develop, and produce vaccines.

Many thousands of people of varying age, race, ethnicity, and different medical conditions have participated in the trials to see how effective and safe they are. The FDA and outside experts carefully review all of the clinical trial data when weighing approval of any new drug or vaccine. When the FDA has approved a vaccine for emergency use, the FDA has determined that the benefits of a vaccine outweigh the risk.

Why should I get a COVID-19 vaccine once one is available for me specifically?
A safe and effective vaccine will help reduce the chance that you get sick from COVID-19, and may help to reduce the spread of the virus, in turn, helping to conserve healthcare resources and help a return to more normal day-to-day activities, including work and school. Many tens of thousands of people of

varying age, race, ethnicity, and different medical conditions have participated in the clinical trials to see how effective and safe COVID-19 vaccines are. Illness from this virus can be severe in some people, leading to hospitalization and potentially, death. If you have questions or concerns about the COVID-19 vaccine, talk to your healthcare provider.

When the FDA has authorized a vaccine for emergency use, the FDA has determined that the benefits of a vaccine outweigh the risk.

Is it possible for people to transmit the virus even after they've been vaccinated?
While the vaccine can eliminate symptoms in individuals, no vaccine is 100% effective, and some vaccine breakthrough infections are expected. Booster doses are expected to lessen the likelihood of developing a breakthrough infection.

Will the COVID-19 vaccines protect against variants to the virus?
The CDC is following that issue closely. To learn more, go here.

Can people get the vaccine if they've already had COVID-19?
Yes, people can get the vaccine if they've already had the infection. Because some evidence suggests that people previously infected can be re-infected, they may benefit from vaccination. For this reason, vaccination should be offered to people regardless of history of prior symptomatic or asymptomatic COVID-19 infection. To learn more, go here.

Post vaccination

Where will vaccination information be recorded?
The vaccination provider may include individual vaccination information in their state or local jurisdiction's Immunization Information system or something similar. This will help ensure that people who have taken the first dose get the same vaccine when they return for the second. For more information, go to this CDC page.

Do fully vaccinated people still need to follow COVID-19 guidelines on masks and social distancing?

The CDC has developed guidance for fully vaccinated people that will be continue to be updated. Please go here for the latest information.

Testing Questions

When testing is used

How is COVID-19 diagnosed?

COVID-19 may be diagnosed based on testing performed because of symptoms, such as fever, cough or difficulty breathing or 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 a laboratory test has detected SARS-CoV-2, the virus that causes COVID-19. Other tests, such as serology tests, should not be used to diagnose current or prior COVID-19 infection.

How are patients tested for COVID-19?

COVID-19 tests are now widely available including at retail pharmacies, through online ordering, in a doctor's office, or drive-through testing sites in some areas. It is usually not necessary to go to an emergency room or hospital merely to get tested. A sample is collected from the nose, back of the throat, or mouth and is either analyzed where collected or sent to a lab.

Blood (serology) tests should not be used to diagnose current COVID-19 infections. While serology tests can help determine prior exposure to SARS-CoV-2, testing is not generally recommended for this use alone.

When testing for COVID-19, do 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.

What are the different kinds of testing?
Testing is often divided into two types: diagnostic and surveillance. Diagnostic testing detects current infection when an individual has symptoms of potential COVID-19 or on asymptomatic individuals with known or suspected exposure to SARS-CoV-2.

Diagnostic testing may use either molecular technology which detects the virus's genetic material or 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 providers to follow CDC guidelines for the use of testing to confirm a current COVID-19 infection.

Surveillance testing occurs on individuals who do not have symptoms or known/documented direct exposure to SARS-CoV-2. This includes potential exposure to SARS-CoV-2 in a high-risk setting and testing for public health monitoring and sentinel surveillance. For example, a high-risk setting would include individuals in long-term care facilities or other congregate living settings, including prisons and shelters.

Antibody testing, also known as serology testing, identifies COVID-19 antibodies, which indicate whether an individual has had a past COVID-19 infection. Serology testing is not recommended for diagnosis of current infection.

Antibody tests are also not recommended 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.

Recently, more labs have started to offer direct-to-consumer testing that can be purchased without a care provider ordering the test. 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 labs' direct-to-consumer programs.

Testing coverage

What costs related to COVID-19 testing are waived?

The following are waived:

- cost-sharing for COVID-19 diagnostic tests as deemed medically necessary by a health care clinician who has made an assessment of a patient, including serology or antibody tests, for members of our employer-sponsored, Individual, Medicare and Medicaid plans. Federal guidance clarifies that a health care provider need not be "directly" responsible for providing care to the patient to be considered a qualifying clinician, as long as the clinician makes an individualized clinical assessment to determine whether the test is medically appropriate for the individual in accordance with current accepted standards of medical practice. 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, including telehealth visits, beginning March 18, 2020 for members of our employer-sponsored, individual, Medicare and Medicaid plans. This is effective throughout the duration of the public emergency.

Are member cost-shares waived for COVID-19 tests required for pre-admission for a procedure unrelated to COVID-19?

In cases where the member is required to take a COVID-19 test as part of pre-admission for an authorized procedure that is unrelated to the treatment of COVID-19, the member's cost-share is waived if the provider determines that the nature of the procedure requires knowledge of the existence of COVID-19 infection for proper treatment.

Will self-insured customers be able to cover testing that is not covered for fully-insured business?
Anthem recommends covering medically necessary testing for diagnosis and treatment only in accordance with federal guidance. Self-insured customers may speak with their Anthem account management team to discuss any coverage questions.

Under what conditions is diagnostic testing covered and cost shares waived?
Cost-share is waived for all medically necessary COVID-19 tests wherever the test is performed including at home, in a pharmacy, 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.

Does the more recent federal guidance on COVID-19 testing change how Anthem covers diagnostic testing?
No, the federal government clarified existing policy, which Anthem has been following, to require that a provider order the test for it to be covered.

We will continue to cover without cost share COVID-19 diagnostic tests performed at a clinical site or at home 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 clinician.

The federal guidance continues to confirm that members are covered for diagnostic testing even if they don't have symptoms of COVID-19, as long as other criteria are met. It also confirmed that insurers are not required to cover back-to-work or surveillance testing.

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.

Surveillance or Screening/Employment/School/Travel testing

What is surveillance testing and when is it covered?
Surveillance testing is testing individuals who do not have symptoms or known exposure to COVID-19. The June 23, 2020 FAQs regarding FFCRA/CARES Act, distinguished surveillance testing from medically necessary testing. Despite the federal guidance, some states have limited, mandated coverage of employment-based testing. Anthem covers federal and state mandated services, as well as services which are medically necessary to diagnose and treat.

Would Anthem cover COVID-19 testing required by schools/universities as a condition to return to campus?
Anthem will cover testing that is medically necessary to diagnose and treat as determined by a health care clinician who has made an assessment of a patient.

Would Anthem cover diagnostic or antibody testing required by schools or universities for members exposed to someone symptomatic of COVID-19 in close settings such as a dorm or classroom?
Anthem will cover testing that is medically necessary to diagnose and treat as determined by a health care clinician who has made an assessment of a patient. The CDC recommends aggressive testing of anyone who is symptomatic, as well as those who are clustered with them in a living space.

Would Anthem cover COVID-19 testing required for travel?
Anthem will cover testing that is medically necessary to diagnose and treat as determined by a health care clinician who has made an assessment of a patient.

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.

Home tests

Does Anthem 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 clinician.

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

Does Anthem provide home testing?
Anthem has purchased a limited number of at-home testing kits for fully insured members and their dependents in all 50 states. This new diagnostic testing option is now available through member portals (Anthem.com or Empire.com) or the Sydney Health mobile app. Using the kit and their smartphone, members can get accurate COVID-19 test results within 10 minutes. The kit typically arrives in two business days or less.

This test is available at no charge for diagnostic testing only. A doctor's order, while normally required for testing to be covered under health plans, is not required when ordering a test through this limited program. The test typically arrives in two business days or less and provides results in 10 minutes. This test is for members who have symptoms of COVID-19 or who have been exposed to someone with confirmed or suspected COVID-19. This Rapid Diagnostic Test for the Detection of SARS-CoV-2 Antigen is an OTC Home Test for use under an FDA

Emergency Use Authorization (EUA) for in vitro diagnostic use only. It is not being made available under FDA authorization for screening purposes.

How is Anthem limiting the number of kits ordered?
The initial launch will limit the test kit to one kit containing two tests per order per member. Primary subscribers will be able to order for themselves and their dependents while dependents can only order for themselves. A member cannot reorder until three days later. As part of the Anthem ordering process, it will be clearly stated that the solution is appropriate for members who currently have symptoms of COVID-19 including known variants or think they have been exposed to the virus. The test is provided only under its diagnostic EUA authorization. Prior to members administering the test, they will be required to self-report their symptoms on the AccessBio application.

Telehealth, Telemedicine, Sydney Health, C19 Navigator and Explorer, Biometric Passport, 24/7 NurseLine and XPrize

Telehealth

Is Anthem encouraging broader use of telehealth assuming the virus spreads?
We are recommending members use telehealth 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 Health app at no cost. The app includes a *Coronavirus Assessment* 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 Health app on Android or iOS.

For Individual Medicare Advantage and GRS: Texting a doctor through Sydney Health is $19 per virtual text visit, including the first visit. Members should go to www.livehealthonline.com for a $0 cost share visit. If they utilize Sydney Health for their LiveHealth Online visit, they will be charged $59 per visit.

Why is telehealth a good option to receive individual health guidance related to COVID-19?
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 a virus while waiting with others at a physical facility.

LiveHealth Online is a safe and helpful way use Anthem 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.

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 copays waived for a 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.

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 Anthem members who have Medicaid, Medicare Advantage, 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 Health

What is Sydney Health?

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

- **Daily COVID-19 Check-In**: A digital tool that allows users to evaluate their health from home before they go to the workplace each day.
- **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 Health 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.

What is the COVID-19 Assessment?

The COVID-19 Assessment is designed based on guidelines from the Centers for Disease Control and Prevention and National Institutes of Health to help anyone 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, users will be able to connect directly to a board certified-doctor via the Sydney Health app who can recommend care options.

How do members find it?

Sydney Health is available for Anthem members to download now on Android or iOS. This app should accompany their Sydney Health or Engage benefits app.

What is the Daily COVID-19 Check-In and how does it work?

The Daily COVID-19 Check-In is a digital tool that allows users to evaluate their health from home before they go to the workplace each day. The tool asks a few

quick questions about recent exposure risks and an employee's health at that moment in time in order to determine their potential COVID-19 risk level. The Daily COVID-19 Check-In also gathers data at the employee and organization level to help employers identify trends and potential risks.

Who can use the check-in tool?
The Sydney Health Daily COVID-19 Check-In is available to anyone who works for an employer that has registered with the app.

How were the check-in questions determined?
The Daily COVID-19 Check-In questions were developed by medical experts to assess risk based on Centers for Disease Control and Prevention guidelines. They cover previous COVID-19 diagnoses, current symptoms, and any social or travel activity.

What happens when employees passes the check-in?
If employees passes the check-in, they will see a green results screen telling them they are at a lower risk for COVID-19, based on their responses.

What happens if employees do not pass the check-in?
If employees do not pass the check-in, they will see a red results screen telling them they are at a higher risk for COVID-19, based on their responses. The app will tell them to contact their employer for instructions on what to do next. Employees can also connect with a doctor within the Sydney Health app to discuss their risk and need for testing.

Do employees need to have Anthem insurance to use the Daily COVID-19 Check-In?
No. Anyone can download Sydney Health. The COVID-19 Assessment and Symptom Checker are free to all users, and The Daily COVID-19 Check-In comes at no extra cost to employees.

How often can employees complete the daily check-in?

Employees will only be able to complete the check-in once every calendar day. At the end of each check-in, employees will be reminded to review their answers for accuracy before submitting.

Can an employee outside the United States or in U.S. territories use the Daily COVID-19 Check-In?
No. At this time, only employees based within the 50 states are able to use the tool.

What is the employer's responsibility in using the tool?
The Daily COVID-19 Check-In gives employers access to relevant data as they decide how to continue bringing employees back to the workplace. While Sydney Health provides helpful data, individual employers are responsible for developing and enforcing policies about what their employees should do after using the tool.

What if a user makes an error on a question during check-in and receives a red results screen?
Employees will be prompted to review their check-in answers for accuracy before submitting each day. However, employers should develop their own policy for what employees should do after receiving a red results screen. The app only tells employees to contact their employer for further instructions. From there, employers can either strictly enforce the results or have an exception process. If employers choose to establish an exception process, they will need to manage it outside the app.

If employees close the app, can they return to their results screen?
Employees can open the app and navigate back to the Daily COVID-19 Check-In page to see the day's results screen.

What should employers do if an employee receives a red results screen and sees a doctor who says they have a low risk for COVID-19?
Employers should develop their own procedure for what employees should do after receiving a red results screen. They can either strictly enforce the results or have an exception process.

Can the check-in be administered manually upon entering the workplace?
Employees can take the check-in wherever they have mobile access. However, employees are encouraged to take this action at home to reduce congestion at security access points.

Do you offer a process for facility entrance clearance, such as a QR code?
Currently, the app does not offer security access integration.

What if employees can't find their workplace listed in the app?
A list of matching workplaces will appear after an employee enters the first three characters in the search bar. If users do not see their workplace listed, they should check the spelling and make sure they're following the instructions given by their employer.

What happens if an employer has not requested access to the Daily COVID-19 Check-In?
If an employer has not requested access to the tool, employees attempting to use the check-in will receive a notification saying their employer is not currently enrolled in the program.

Does Sydney Health obtain employee consent to share their Daily COVID-19 Check-In status?
Yes, the Daily COVID-19 Check-In includes an authorization, consistent with applicable law, to disclose the employee's status and underlying responses to their employer. This data is collected, used, and maintained in accordance with the app's Privacy Policy.

Does Sydney Health allow employers to address state privacy obligations, including the California Consumer Privacy Act, also known as CCPA?
Yes, Sydney Health will maintain a CCPA Notice and looks to employers to administer individual rights requested under the CCPA.

Where will employees find the Daily COVID-19 Check-In?
The Daily COVID-19 Check-In is located in the COVID-19 Resource Center within the Sydney Health app. It can be found by:

- Selecting the COVID-19 Resource Center pop-up that appears when the app is opened.
- Choosing COVID-19 Resource Center from the menu in the top left corner.

How can users start using the Sydney Health app?
Employees can download the Sydney Health app from the App Store® or Google Play™. Once they register, they will be able to use the features Sydney Health offers.

If employees have a technical issue with Sydney Health, what should they do?
They should email support@sydneycare.ai for assistance with technical issues.

C19 Explorer and C19 Navigator

What is C19 Explorer?
Intended for government officials, as well as business, healthcare, and community leaders, C19 Explorer provides intuitive, interactive dashboards on specific data related to the risks and impact of the COVID-19 pandemic as a decision support tool for return to work/office and reopening and other future decisions. Users may drill down to a county level for infection rate, hospitalization, and unemployment rates, and also assess workforce testing needs and social determinants of health including food insecurity. C19 Explorer is a public utility available at no charge to the general public via https://c19explorer.io/.

What is C19 Navigator?
C19 Navigator is designed for Anthem employer customers (and prospects), including states and other governmental entities, for their plan population. C19 Navigator builds upon the public data insights of C19 Explorer and provides specific clinical insights related to the co-morbidities of the employee base that are linked to data of the local communities. As a customized decision support tool, C19 Navigator is able to assist employers with associate considerations as part of their reopening decisions and plans. Medicare and Medicaid officials are able to leverage the predictive and analytic capacity of C19 Navigator to anticipate needs and assess trends during the pandemic, as well as for future planning purposes. C19 Navigator will continue to evolve to meet the needs of employers and government officials. Anthem employer customers, as well as

Medicare and Medicaid officials, should work with their Anthem business partners regarding access to this tool.

What is C19 Vaccine? 1/22/2021

C19 Vaccine is a publicly available dashboard, developed by Anthem as part of the C19 Navigator and C19 Explorer, that provides national and state-level data on COVID-19 vaccine distribution, administration and allocation. C19 aggregates vaccine-related data daily from top public sources, such as the CDC, US Bureau of Labor and Statistics, the US Census Bureau, the USDA, USAFacts.org, and the Kaiser Family Foundation, and other private and proprietary data sources.

C19 Vaccine offers the following data:

- Status of vaccine administration by state in heat map format
- Vaccine allocation and distribution data by manufacturer, including total vaccine doses distributed and vaccines administered
- Segmented population by vaccination priority
- Percent of population vaccinated nationally and by state

Vaccine candidate data, including trial status, number of doses required, and federal government purchase agreements

Will Anthem business customers access C19 Navigator on their own or will they have to go through an account representative?

Anthem clients get access to information via the C19 Navigator through their account representative and/or through the client facing application CII Discover, if they have direct access.

How are Anthem's COVID-related tools different than others?

The Anthem tools bring together actionable insights at the member level (C19 Navigator), while visualizing publicly available data to inform decision making (C19 Explorer).

Where does this data come from? And is it up-to-the-minute data?

C19 Explorer data sources include: CDC, WHO, US Bureau of Labor and Statistics, United States Census Bureau, United States Department of Agriculture, Google Foot Traffic, Delphi Research Group, SafeGraph, KFF, and various private data sources. The data on C19 Explorer is updated at least every 24 hours. C-19

Navigator using the same base data as C19 Explorer with specific Anthem member datasets.

Can I add my own data to the visualizations in C19 Explorer?
Yes, if you have a data set that you do not wish to make public, we can work with you to create a password protected 'C19 Explorer Privileged' view that creates a password protected custom incorporation of existing C19 Explorer data with your private data set. Depending on the complexity of the custom integration scope, there may be an associated cost for development.

Why did you choose these partners in developing C19 Explorer?
Each company involved in developing these tools is passionate about making the latest, most valuable data available seamlessly to leaders to make informed decisions as we navigate this crisis. The companies involved in this collaborative effort are: Anthem, Inc., CloudMedx, and TM.

How are you protecting member data?
Anthem takes the security of its data and the personal information of consumers very seriously. We are committed to safeguarding our members' data, including their Protected Health Information (PHI) and Personally Identifiable Information (PII). Anthem utilizes robust technology and data security processes that include vulnerability monitoring and penetration testing. Through these precautions C19 Navigator is fully HIPAA compliant.

If Anthem is using member data to inform these insights for employers and group health plans, will these Anthem clients know which of their employees/members and health plan dependents developed COVID-19?
The data shared with Anthem clients are based on the privacy requirements outlined in legal arrangements between Anthem and its clients.

Biometric Passport

What is Biometric Passport?
Biometric Passport includes the ability to evaluate employees' possible COVID-19 symptoms through daily attestations, empowering employers to use this information for workforce management planning. This tool collects a user's health

information through a simple, daily survey and generates an encrypted QR code. Responses stay on a user's phone – and are never shared with the employers. Employers will only know whether or not the employee is granted access to enter their facilities based on their requirements. There is a link to download the app on www.anthem.com/recovery.

XPrize

How is Anthem involved in XPRIZE and Rapid Covid Testing?

Anthem Inc. and the Anthem Foundation are founding anchor partners in a coalition of organizations, including other health and technology companies, which are supporting the XPRIZE Rapid Covid Testing competition. The competition aims to increase COVID-19 testing capabilities faster than our current standard, reduce the cost of testing, and make it easy to use. This effort is designed to help people more safely return to everyday activities.

Pharmacy Questions

Do drugs exist to treat COVID-19? 10/8/21

Casirivimab and Imdevimab

The FDA has granted Emergency Use Authorization of casirivimab and imdevimab, a combination antibody therapy administered together and made by Regeneron. Coverage will be made available based on the EUA indication and in accordance with FDA guidance.

The FDA EUA indicates casirivimab and imdevimab can be used in adults and pediatric patients age 12 and older weighing at least 88 pounds (40 kg):

- to treat mild to moderate COVID-19 in with individuals with positive results of COVID-19, and who are at high risk for progressing to severe COVID-19 and/or hospitalization. Casirivimab and imdevimab may only be administered together. It should be given as soon as possible after a positive test and within 10 days of symptom onset.

- for post-exposure prevention of COVID-19 in persons who are:

- not fully vaccinated against COVID-19 (Individuals are considered to be fully vaccinated 2 weeks after their second vaccine dose in a 2-dose series, such as the Pfizer or Moderna vaccines, or 2 weeks after a single-dose vaccine, such as Johnson & Johnson's Janssen vaccine

or

- are not expected to build up enough of an immune response to the complete COVID-19 vaccination (for example, someone with immunocompromising conditions, including someone who is taking immunosuppressive medications),

and

- have been exposed to someone who is infected with SARS-CoV-2. Close contact with someone who is infected with SARS-CoV-2 is defined as being within 6 feet for a total of 15 minutes or more, providing care at home to someone who is sick, having direct physical contact with the person (hugging or kissing, for example), sharing eating or drinking utensils, or being exposed to respiratory droplets from an infected person (sneezing or coughing, for example).

or

- someone who is at high risk of being exposed to someone who is infected with SARS-CoV-2 because of occurrence of SARS-CoV-2 infection in other individuals in the same institutional setting (for example, as nursing homes, prisons).

Distribution will be controlled by federal government, which will collaborate with local and state governments.

Anthem is waiving cost-sharing for the treatment of COVID-19 by in-network providers from April 1 through Jan. 31, 2021 for members of its fully-insured employer, Individual and Medicaid plans. Cost-sharing for members with Medicare Advantage and Medicare GRS plans is waived until Feb. 28, 2021.

Bamlanivimab and etesevimab

The Food and Drug Administration has granted Emergency Use Authorization of bamlanivimab and etesevimab, a COVID-19 antibody therapy made by Eli Lilly. Coverage will be made available based on the EUA indication and in accordance with FDA guidance.

The FDA EUA indicates bamlanivimab and etesevimab can be used in adults and pediatric patients age 12 and older weighing at least 88 pounds (40 kg) to:

• treat mild to moderate COVID-19 in individuals with positive results of COVID-19, and who are at high risk for progressing to severe COVID-19 and/or hospitalization. Casirivimab and imdevimab may only be administered together. It should be given as soon as possible after a positive test and within 10 days of symptom onset.

• post-exposure prevention of COVID-19 in persons who are:

o not fully vaccinated against COVID-19 (Individuals are considered to be fully vaccinated 2 weeks after their second vaccine dose in a 2-dose series [such as the Pfizer or Moderna vaccines], or 2 weeks after a single-dose vaccine [such as Johnson & Johnson's Janssen vaccine]),

or

• are not expected to build up enough of an immune response to the complete COVID-19 vaccination (for example, someone with immunocompromising conditions, including someone who is taking immunosuppressive medications),

and

• have been exposed to someone who is infected with SARS-CoV-2. Close contact with someone who is infected with SARS-CoV-2 is defined as being within 6 feet for a total of 15 minutes or more, providing care at home to someone who is sick, having direct physical contact with the person (hugging or kissing, for example), sharing eating or drinking utensils, or being exposed to respiratory droplets from an infected person (sneezing or coughing, for example).

or

- someone who is at high risk of being exposed to someone who is infected with SARS-CoV-2 because of occurrence of SARS-CoV-2 infection in other individuals in the same institutional setting (for example, as nursing homes, prisons).

At this time, the federal government covers the cost of bamlanivimab and etesvimab. The U.S. government has committed that patients will have no out-of-pocket costs for bamlanivimab and etesevimab, although healthcare facilities may charge a fee to administer the antibody therapy. When an administration fee is charged for a therapy covered by an EUA, Anthem will cover the costs of administration from in-network providers under the member's medical benefit.

Sotrovimab

The Food and Drug Administration has granted Emergency Use Authorization of sotrovimab, a COVID-19 antibody therapy made by GSK. Coverage will be made available based on the EUA indication and in accordance with FDA guidance.

The FDA EUA indicates sotrovimab can be used in adults and pediatric patients age 12 and older weighing at least 88 pounds (40 kg) to treat mild to moderate COVID-19 in individuals with positive results of COVID-19, and who are at high risk for progressing to severe COVID-19 and/or hospitalization. Casirivimab and imdevimab may only be administered together. It should be given as soon as possible after a positive test and within 10 days of symptom onset.

At this time, the federal government covers the cost of sotrovimab. The U.S. government has committed that patients will have no out-of-pocket costs for sotrovimab, although healthcare facilities may charge a fee to administer the antibody therapy. When an administration fee is charged for a therapy covered by an EUA, Anthem will cover the costs of administration from in-network providers under the member's medical benefit.

Veklury/remdesivir

On Oct. 1, 2020, the Food & Drug Administration approved Veklury, or remdesivir, as the first drug to treat COVID-19 for use in adults and patients older than 12 who require hospitalization.

Anthem does provide coverage for remdesivir, which is currently only administered in the hospital or similar healthcare setting capable of providing acute care. Anthem is waiving cost-sharing for the treatment of COVID-19 by in-network providers from April 1 through Jan. 31, 2021 for members of its fully-insured employer, Individual and Medicaid plans. Cost-sharing for members with Medicare Advantage and Medicare GRS plans is waived until Feb. 28, 2021.

On June 29, 2020, Gilead released both its commercial and government pricing for Remdesivir. For commercial, non-government insurers, Gilead will charge $520 per vial. A five-day, six-vial course of treatment will cost $3,120 per patient. A 10-day, 11-vial course will cost $5,720 per patient. The U.S. government will be billed $390 per vial, equating to a $2,340 five-day, six-vial course of treatment per patient, and a $4,290 10-day, 11-vial course of treatment. Remdesivir is currently only administered in the hospital setting and is billed as part of the medical benefit.

Other non-FDA-approved drugs in treatment of COVID-19

Several other FDA-approved drugs not indicated for the treatment of COVID-19 but recommended in the NIH guidelines include dexamethasone (other corticosteroids prednisone, methylprednisolone, or hydrocortisone may be used if dexamethasone is not available), baricitinib, tofacitinib, tocilizumab, and sarlimumab.

Dexamethasone

- Dexamethasone, a steroid treatment available for more than 50 years, has not been approved by the FDA to treat COVID-19. Dexamethasone will be covered by Anthem based on the results of the RECOVERY study and National Institutes of Health recommendations for use in hospitalized patients. The recently announced preliminary findings of the UK-based

Randomised Evaluation of COVID-19 Therapy (RECOVERY) study showed that dexamethasone may result in one life saved in every eight patients treated on ventilators and one life saved in every 25 patents treated using oxygen alone. Based on the RECOVERY trial, the COVID-19 Treatment Guidelines Panel of the National Institutes of Health issued the following recommendations on the use of dexamethasone for COVID-19 The panel recommends using dexamethasone (at a dose of 6 mg per day for up to 10 days) in patients with COVID-19 who are mechanically ventilated and in patients with COVID-19 who require supplemental oxygen but who are not mechanically ventilated.

- The panel recommends against using dexamethasone in patients with COVID-19 who do not require supplemental oxygen.
- While these preliminary results are a promising, more research is needed to confirm these findings.

We will monitor the drug supply.

Baracitinib was granted an Emergency Use Authorization for treatment of COVID-19 in hospitalized adults and pediatric patients 2 years of age or older requiring supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO).

Tocilizumab was granted an Emergency Use Authorization for EUA for the emergency use for the treatment of COVID-19 in hospitalized adults and pediatric patients (2 years of age and older) who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation.

Hydroxychloroquine and chloroquine

On June 15, 2020, the FDA removed Emergency Use Authorization for the anti-malaria drugs chloroquine and hydroxychloroquine. The EUA had allowed the drugs to be used for the treatment of COVID-19 for those patients meeting specific clinical criteria. We are monitoring developments in this area closely and will evaluate coverage of any treatments once approved.

Ivermectin

Ivermectin tablets are FDA-approved at very specific doses to treat some parasitic worms, and there are topical (on the skin) formulations for head lice and skin conditions like rosacea. The FDA has received reports of individuals using the oral tablets for humans and other forms used in animals to prevent or treat COVID-19 infection. Data are insufficient to determine if ivermectin safe or effective for treatment or prevention of COVID-19 infection. We are monitoring developments in this area closely and will evaluate coverage of any treatments once approved.

How are you handling off-label use of approved FDA drugs? What steps are you taking that sufficient supply remains for on-label use? 3/18/21

- 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.
- We are closely monitoring utilization of chloroquine and hydroxychloroquine and regularly evaluating the need to place additional controls on these drugs.
- 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? 3/18/21

- We are closely monitoring utilization of chloroquine and hydroxychloroquine and regularly evaluating the need to place additional controls on these drugs.
- 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.

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

- Anthem'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 within 15 days of their recommendation by either the Advisory Committee on Immunization Practices of the Centers for Disease Control or the U.S. Preventive Services Task Force.
- 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.

Anthem 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, Anthem 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 Anthem 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 Anthem 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.
- Anthem, and its PBM IngenioRx, will follow the directives from HHS and the DEA, as well as any superseding local regulations, related to this issue.

- Anthem 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 Anthem/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 Anthem 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. Anthem will not cover these tests.
- Anthem 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 Anthem doing to support behavioral health and emotional wellness during COVID-19?

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

- Anthem'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.

- Anthem 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).
- Anthem 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.
- Anthem health plans with Employee Assistance Programs offer individual and employer-sponsored members up to six free sessions with a behavioral health counselor.

Anthem'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 Anthem's Employee Assistance Program, other employer-based programs and Medicaid members in Florida, Texas, Washington and Washington D.C.

How does Anthem waive cost shares for telehealth behavioral health services?
From March 17 through Oct. 1, 2020, Anthem is waiving member cost share for telehealth visits, including visits for mental health or substance use disorders, for members of our employer-sponsored, individual, Group Retiree Solutions, 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.

For members of our Medicare Advantage plans, from March 17 through Jan. 31, 2021. Anthem is waiving member cost share for telehealth visits, including visits for mental health or substance use disorders.

How can Anthem's Employee Assistance Programs assist members at this time?
Anthem 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. Access to the Anthem EAP website resources are free through Dec. 31, 2020 for any member without an EAP.

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 Anthem's philanthropic arm, the Anthem 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, Anthem 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 Anthem 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. Anthem 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

Will the probationary period for new hires be waived?
Newly hired employees will be subject to the waiting period.

What is Anthem's position on IRS Notice 2029-29 regarding §125 Cafeteria Plans? Specifically, will Anthem 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?
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.

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

How much does the diagnostic test cost?
The CMS fee for the COVID-19 diagnostic test alone generally ranges between $25 and $65. However, there are a number of variables that may add additional fees, such as, site of care, additional simultaneous testing (nasal and mouth swabbing)

and number of samples tested. Members have no financial responsibility for the diagnostic test.

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?
Anthem 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 Anthem will review and take appropriate action. Anthem 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. Anthem 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 Anthem 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: IND Segment grace periods continue to be evaluated monthly with some states continuing grace period extensions and other states returning to business as usual. For the most up-to-date guidance for

non-subsidized members please refer the chart on page 3 of the IND Segment Huddle Topic.

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).

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 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 or would have the option to purchase a short-term plan that is subject to medical underwriting.	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 or would have the option to purchase a short-term plan that is subject to medical underwriting. If Anthem is a customer's stop loss carrier, the policy will terminate if the minimum enrollment of active employees threshold is not met. If Anthem is not a customer's stop loss carrier, Anthem recommends verifying coverage and minimum enrollment requires with your 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
No.	No.

Will Anthem allow coverage reinstatement for failure to pay premium?

At this point in time, Anthem'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 Anthem'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 Anthem renewal rate actions or quote responses be delayed?

Anthem is committed to delivering our renewals within our normal schedule and meeting deadlines on delivery of quotes.

Will employer rates/premium be subject to change if enrollment drops by more than 10 percent as a result of the COVID-19 crisis?
Yes.

If laid-off employees lose their health insurance coverage, will Anthem be able to offer coverage options?
Anthem recommends employers work with their employees to assess coverage options and eligibility by sharing the COVID-19 Coverage Option Hotline at 1-888-832-2583 where employees will be guided through their options. Some examples of options include Medicaid or qualifying event for a special enrollment period for an ACA compliant plan. If Medicaid or ACA compliant plans is not a fit for your employee, they may also consider a short-term plan if available in their state. Also, COBRA or state continuation should be made available as well.

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.anthem.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.

For those who chose to enroll in a short-term plan, how quickly will their coverage be effective?
Short-term plans, where available, will typically be reviewed and approved by the plan's underwriters and will be effective the day after formal underwriting approval.

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 Anthem provide relief to the member?
No. At this point in time, Anthem'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 Anthem extend their open enrollment period?
Anthem 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, Anthem will not be able to place high-dollar claims on hold.

What is Anthem's policy for reinstating employees who were terminated or furloughed and lost coverage?
If the employee is rehired or converted to actively at work within 30 days of termination or date of furlough, the standard will be to reinstate as of the original effective date. This means:

- No break in coverage
- Employer is 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 30 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 31-61 days (or 31-365 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.

Will late charges apply to ASO groups?

Yes.

If an ASO group is terminated for non-payment after being delinquent for 12 days, what is the termination date?

Termination date will be the last date for which amounts due are fully paid.

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 Anthem 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 Anthem 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

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 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 an employee terminated due to COVID-19 without requiring a new Eligibility Waiting Period or Evidence of Insurability?

- For employees who are terminated due to COVID-19 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 the amount of time you were previously insured under your Anthem policy toward the satisfaction of policy time limits. In addition, the employee's original effective date will be used to determine if a pre-existing condition review is warranted.

- For employees who are rehired after 12 months and reinstate coverage, we will treat them as newly hired employees.

Can employees who voluntarily terminate coverage due to COVID-19, but remain employed, re-enroll later without requiring a new Eligibility Waiting Period, Evidence of Insurability or Pre-existing Condition review?

- For employees who voluntarily terminate coverage due to COVID-19, remain employed with the same employer, and re-enroll for coverage within six months at an equivalent plan design, we will not require a new Eligibility Waiting Period or EOI. We will credit the amount of time you were previously insured under your Anthem policy toward the satisfaction of policy time limits. In addition, the employee's original effective date will be used to determine if a pre-existing condition review is warranted.
- For employees who voluntarily terminate coverage due to COVID-19, remain employed with the same employer, and re-enroll between six and 12 months at an equivalent plan design, we will not require a new Eligibility Waiting Period or EOI. We will credit the amount of time you were previously insured under your Anthem policy toward the satisfaction of policy time limits. However, if the coverage has a pre-existing condition exclusion, employees will be subject to a pre-existing condition review for new conditions they sought treatment for during the period between their active status ending and their return to active status with the employer.
- For employees who voluntarily terminate coverage due to COVID-19, remain employed with the same employer and re-enroll after 12 months, we will treat them as newly hired employees.

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.

Will an extension of the grace period for premium payment be provided?
If a group is bundled with medical and an extension for medical is approved, the extension will apply to all lines of business.

For requests for extensions to life and disability plans on the Compass system, sales associates can send requests to the appropriate regional mailbox listed below and copy Angela Sillus and Ka Feola.

East Region – EastRegion@anthem.com
Central Region - CentralRegion@anthem.com
West Region - WestRegion@anthem.com

The following details should be included in the request:

- Name of the group
- Group number
- Paid to date
- Amount currently owed
- What month(s) are they asking for an extension

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

Does Anthem administer state-mandated disability plans for our customers?
We administer the New York Paid Family Leave for a number of our customers that have New York based employees.

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 Anthem 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 Anthem 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, Anthem 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 Anthem 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 Anthem 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, Anthem 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.anthem.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.

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.anthem.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.anthem.com and select "Contact Us."

How is Anthem 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, Anthem Dental does provide transition of care and coverage according to the contract and benefits.

Is Anthem 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 Anthem 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 Anthem 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.anthem.com and select "Contact Us."

How is Anthem 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 announced as of May 1, 2020, we are providing nationwide network access to board-licensed dentists for emergency dental care through TheTeleDentists®. 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 Anthem honor dental care through teledentistry after the COVID-19 pandemic?

Yes. Anthem 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 Anthem 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 June 30, 2021, 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 Anthem handling issues related to underwriting guidelines and changes in workforce?

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

Is Anthem 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 PPE as they open their offices to patients for routine care and follow strict protective guidelines. As a result, we are reimbursing dentists in our PPO networks for PPE costs by implementing a $10 temporary payment of PPE per visit starting on June 15 through Dec. 31, 2020. 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 co-pays from members at time of dental visits. Network providers cannot balance-bill members for PPE above the $10 reimbursement. All fully-insured and self-funded employer groups are automatically included; however, self-funded employer groups can opt-out of covering PPE reimbursement by notifying us by Nov. 13.

How are you helping your insured dental customers with premium relief during the COVID-19 crisis?
We provided all fully-insured large and small group customers as well as individual dental customers with premium credits to help them with their benefit costs during a period when members were unable to visit dentists for routine care, reflected in a reduced volume of claims paid. The Dental premium credit appeared on all fully-insured group billing statements released in July 2020, with a 50% credit for their April 2020 dental premiums. Individual dental customers received a check, with Individual ACA customers receiving their payment in September and non-ACA customers receiving their payment in August.

For benefit plans that have a services waiting period (such as 12 months for major or orthodontic dental services), if an employee is laid off and then subsequently rehired in a few months, will the rehired employees be subjected to the benefit waiting period all over again?
No. Employees rehired by March 31, 2021, will not be subject to waiting periods for benefit plans that have service waiting periods provided they have satisfied their waiting periods previously.

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 Anthem 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, Anthem 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 Anthem 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, Anthem 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.anthem.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?

We have six online providers members may use from the comfort of their homes. They include: LensCrafters, 1800Contacts, Ray-Ban, Target Optical, Glasses.com, and Contactsdirect.
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 Anthem 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 Anthem handling issues related to underwriting guidelines and changes in workforce?
Anthem 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 June 30, 2021, 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.
- Accounts that currently allow for the reimbursement of OTC items will automatically include the expansion of OTC medications. Only Member Pay HRA with debit card are eligible for OTC reimbursement.

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").

Will Anthem reinstate due dates on March 1, 2021? 3/18/21
Yes. Timeframes will be reinstated ***starting*** as of 12:00 a.m. March 1, 2021. This means that plans and members should submit claims and any updated eligibility information as soon as possible if they wish to take advantage of the relief initially provided under the **Federal Guidance**.

Under **Notice 2021-01**, the Department of Labor clarified that each ***eligible*** individual has his/her own one-year "Outbreak Period," unless the National Emergency terminates prior to the end of that one-year period.

Individuals and plans with timeframes that are subject to the relief will have timeframes suspended until the earlier of (a) 1 year from the date they were first eligible for relief; or, (b) 60 days after the announced end of the National Emergency (the end of the Outbreak Period).

The first date upon which an individual or plan could be eligible for relief was March 1, 2020, the first day of the National Emergency. Therefore, the earliest date upon which a disregarded period can begin to run again is March 1, 2021.

Which timeframes are suspended under Federal Guidance? 3/18/21
ERISA group health and disability plans must push back the following:

- The 30-day period (or 60-day period, if applicable) to request special enrollment with a qualifying event.
- 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.

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, 2020 until timeframes are reinstated.

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.

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 until March 1, 2021. Anthem will forward independent external reviews requests consistent with plan timeframes.

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? 3/1/21
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 while timeframes are suspended, 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? 3/18/21

Although timeframes have been suspended, timeframes have not changed. 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 as well as notice that timeframes are scheduled to be reinstated starting March 1, 2021.

What is the impact of the Federal Guidance to COBRA payment due dates? 3/1/21

Any days that occur while timeframes are suspended 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 due to the Federal Guidance? 3/1/21

No. The guidance does not require employers to pay COBRA enrollee's premiums.

What happens if no payment or only partial payment is made? 3/1/21

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.

What is the effective date of coverage for participants who take advantage of a special enrollment period due to Federal Guidance?

Generally, Anthem will enroll participants in a manner consistent with eligibility determinations made by the group health plan. Coverage will begin no later than the first day of the first calendar month beginning after the date the plan receives the request for special enrollment.

Will Anthem pend or reject claims if payment is not made?

Anthem 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.

What are some of the more common examples related to COBRA continuation benefits that members and employers have been asking about?
Example 1: COBRA enrollee elects COBRA coverage effective April 1, 2020 but does not pay COBRA premium. However, group pays COBRA enrollee's premium for April and May. Group requests that Anthem retroactively term, effective April 1.
Under this example, Anthem will permit the retroactive termination. Generally, Anthem's standard processes permit retro terminations up to 60 days, but terminations beyond 60 days require underwriting approval. Claims paid for the member may not be able to be recouped, even if the member is retro terminated.
Example 2: COBRA enrollee elects COBRA coverage effective April 1, 2020 but does not pay COBRA premium. However, group pays COBRA enrollee's premium for April, May, and June. Group requests that Anthem retroactively term, effective April 1.
Under this example, Anthem will permit the retroactive termination but may make the termination effective May 1, 2020. Generally, Anthem's standard processes permit retroactive terminations up to 60 days, but terminations beyond 60 days require underwriting approval. Claims paid for the member may not be able to be recouped, even if the member is retroactively terminated.
Example 3: COBRA enrollee elects COBRA coverage effective April 1, 2020 but does not pay COBRA premium. Group does not pay COBRA enrollee's premium. COBRA enrollee pays premium for April and May. Group requests that Anthem retroactively enroll member, effective April 1.
Under this example, Anthem will permit the retroactive enrollment. Anthem will reprocess claims incurred on or after April 1.

Are Anthem's customer service representatives equipped to address questions from group customers regarding Federal Guidance? Anthem'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 Anthem 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? 3/1/21

The timeframe is correct, but Anthem will disregard days that occur while timeframes are suspended. If the notice includes a due date, this due date can be used to determine how much additional time is available once timeframes are reinstated.

A member received a notice that COBRA coverage will be cancelled if payment is not made within a certain timeframe. Is this correct? 3/1/21

Anthem's COBRA administrator Wageworks may send out notices on behalf of Anthem. The timeframe is correct but Anthem will disregard days that occur while timeframes are suspended. If the notice includes a due date, this due date can be used to determine how much additional time is available once timeframes are reinstated.

How much additional time will members or employers have to submit eligibility, COBRA payment, or claims information? 3/1/21

It depends. While timeframes are suspended until March 1, 2021, 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 timeframes are reinstated? 3/1/21

Anthem will cascade notice to group health disability plans timeframes are scheduled to be reinstated. However, we recommend monitoring the Department of Labor's website for additional updates.

State Mandate Questions

Maine

What changes has Anthem made to address Maine's law regarding COVID-19?
COVID-19 testing: Anthem is providing coverage for screening and diagnostic testing for COVID-19 without deductible, copayment, coinsurance or other cost-sharing requirement for the costs of COVID-19 screening and testing, including all associated costs of administration. Testing need not be ordered by a physician or clinician.

Testing for COVID-19 includes home and self-administered COVID-19 diagnostic tests.

The waiver of cost-sharing including co-pays, deductibles, and coinsurance for testing for COVID-19 is effective March 25, 2021, for our fully-insured employers, individual, MEWA, and Maine State Employee Health Plan members. Self-insured plans may opt into this program.

New York

Why is Empire waiving cost sharing for in-network outpatient mental health services for fully-insured commercial members?
On May 2, 2020, the Department of Financial Services ("DFS") issued an emergency regulation requiring the waiver of cost sharing for in-network outpatient mental health visits for essential workers due to the pandemic. DFS also issued Circular Letter No. 10 (2020) on the same issue. The regulation and Circular Letter came as a result of Governor Cuomo's announcement made during his May 1st COVID-19 news conference of the need to provide access to these services for first responders and other essential employees. Empire is implementing the DFS regulation and extending to include all commercial fully-insured members inclusive of essential workers.

This waiver originally took effect for 90 days, starting May 2, 2020, for all New York fully-insured members, including essential workers for outpatient mental-health visits with doctors and facilities in our health plans' networks. The waiver applies to outpatient mental-health visits on or after May 2. It does not apply to deductibles in high-deductible health plans. The emergency regulation containing the waiver has been extended several times, and is currently set to end on September 28, 2020.

Empire will also continue to waive members' mental health cost share for in network services until September 28, or any later extension date, for self-insured and ASO groups that previously requested this waiver on their plans, unless they advise us in writing that they no longer want this to apply.

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), and Medicaid plans. This impacts all New York Empire members, inclusive of national accounts. Sales representatives from the National account department will contact these groups separately.

Will Empire be removing prior authorization requirements for scheduled surgeries or admissions at hospitals?

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 for Individual, employer-based fully-insured and self-insured (ASO)*, Medicare** and Medicaid plans.

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.

Safety and Preparedness Questions

How is Anthem responding to COVID-19?
Anthem is committed to help provide increased access to care, help alleviate the added stress on individuals, families and the nation's healthcare system, while eliminating certain costs.
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 Anthem's affiliated health plans to remove barriers for their members and support communities through this unprecedented time.
Anthem 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.

Is Anthem waiving member cost share for diagnostic tests, visits and treatments related to COVID-19? 8/13/21
Anthem is committed to help our members gain timely access to care and services and are actively monitoring developments with the pandemic and possible

extensions of decisions previously made by Anthem. Our actions should help reduce barriers to seeing a doctor, getting tested and receiving treatment. Anthem is waiving:

- cost-sharing for the treatment of COVID-19 by in-network providers from April 1 through Jan. 31, 2021 for members of its fully-insured employer, Individual and Medicaid plans. Cost-sharing for members with Medicare Advantage and Medicare GRS plans is waived until Feb. 28, 2021.
- 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 as deemed medically necessary by a health care clinician who has made an assessment of a patient, including serology or antibody tests, for members of our employer-sponsored, Individual, Medicare and Medicaid plans. Recent federal guidance clarifies that a health care provider need not be "directly" responsible for providing care to the patient to be considered a qualifying clinician, as long as the clinician makes an individualized clinical assessment to determine whether the test is medically appropriate for the individual in accordance with current accepted standards of medical practice. 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, including telehealth visits, beginning March 18, 2020 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 for COVID-19 treatment from March 17 through Jan, 31, 2021 for our fully-insured employer, and individual plans, and where permissible, Medicaid plans. Cost-sharing for members with Medicare Advantage and Medicare GRS

plans is waived until Feb. 28, 2021. Self-funded plans that had already chosen to opt-in could continue to do so through Jan. 31, 2021.

- cost sharing for non-COVID-19 related telehealth services from Anthem's telehealth provider LiveHealth Online from March 17, 2020 through May 31, 2021 for our fully-insured employer, individual, and where permissible, Medicaid plans. Medicare Advantage members pay no member cost share for LiveHealth Online, regardless of national emergency.
- cost-sharing for telehealth visits from in-network primary care providers during 2021, including visits for mental health or substance use disorders, for Medicare Advantage.
- cost-sharing for telehealth visits for in-network providers for **non-COVID-19** services for Medicaid continue without cost share as usual, where permitted.
- cost-sharing for audio-only, in-network provider telephonic only visits through Dec. 31, 2021 for fully-insured employer-sponsored, individual, Medicare and Medicaid plans. Self-funded plans that have already chosen to opt-in may continue to do so through Dec. 31, 2021.
- cost-sharing for audio-only, in-network provider telephonic only visits through Dec. 31, 2021 for Medicare Advantage Plans.
- cost-sharing and coverage for COVID-19 vaccines and their administration for all members in-network or out-of-network within 15 days of their recommendation by either the Advisory Committee on Immunization Practices of the Centers for Disease Control or the U.S. Preventive Services Task Force.

The cost-sharing waivers noted above includes co-pays, 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.

Prior authorizations

COVID-19 related prior authorizations are suspended. From March 26 through Dec. 31, 2020, Anthem will cover respiratory services for acute treatment of COVID-19 and will suspend prior authorization requirements on durable medical

equipment and respiratory services critical for the treatment of COVID-19, including oxygen supplies, respiratory devices, continuous positive airway pressure, CPAP devices, non-invasive ventilators, and multi-function ventilators. From March 1 through May 30, 2020, Anthem suspended select prior authorization requirements to allow care providers to focus on caring for patients diagnosed with COVID-19, including suspension of prior authorization requirements for patient transfers, prior authorization requirements for skilled nursing facilities.

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

The health and safety of Anthem associates and the various stakeholders we serve is a top priority for our business every day. Anthem 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. Anthem 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. Anthem also maintains a dedicated internal mailbox for questions from our Anthem associates about COVID-19.

How is Anthem communicating with consumers, customers, employees and vendors to deliver important news and take in questions?

The health and safety of Anthem associates and the various stakeholders we serve is a top priority for our business every day. Anthem communicates to our members, employers, and producers on our website at www.anthem.com. On this blog there are both general information about COVID-19 and prevention and treatment and information about how Anthem members' coverage covers testing and treatment for COVID-19.

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

How is Anthem monitoring COVID-19?

Anthem'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 Anthem's Virtual Command Center for Emergency Management command, control and communication. In addition, Anthem 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 Anthem have a business continuity plan in the event of a pandemic?

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

Applicable law limits Anthem's ability to share an individual's protected health information with an employer absent an authorization or certain extenuating circumstances. As a result, Anthem 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, Anthem 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 Anthem provide to a self-insured group looking to potentially expand its benefit coverage amid the COVID-19 response?

Anthem 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, Anthem 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. Anthem 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 Anthem 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, Anthem can consider releasing the data.

Anthem 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 Anthem 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 Anthem 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.

What diagnosis code is appropriate to ensure member cost sharing is waived for COVID-19 treatment?

Anthem looks for the diagnosis code U07.1 to identify claims related to the treatment for COVID-19. Benefits will be applied in accordance with our announcements concerning waiver of cost shares for treatment of COVID-19.

How will Anthem cover telehealth (audio and video) for physical, occupational, and speech therapies?

From March 17, 2020 through March 31, 2021, Anthem will cover telehealth visits for physical, occupational, and speech therapies for members of its fully-insured employer, Individual, and Medicare Advantage plans. Medicaid, where permissible, will cover telehealth for physical, occupational and speech therapies.

What modifier is appropriate to waive member cost sharing for COVID-19 testing and visits related to testing?

Anthem looks for the CS modifier to identify claims related to evaluation for COVID-19 testing. This modifier should be used for evaluation and testing services in any place of service.