Coronavirus (COVID-19) FAQs
for Sanford Health Plan Employers

Through the evolving COVID-19 outbreak, Sanford Health Plan is dedicated to keeping you informed about the latest coverage and care updates as partners in your care. Here are some things you should know.

Coverage and Care:

Will Sanford Health Plan cover COVID-19 vaccines?
Sanford Health Plan will cover 100 percent of charges related to the vaccine. This includes the amount for the office visit to administer the vaccine.

How will Sanford Health Plan cover testing and treatment for COVID-19?
Testing: Members will not pay copays, deductibles or coinsurance for medically necessary tests to diagnose COVID-19. This includes the COVID-19 tests, antibody tests, specimen collection, and any related rule out tests to make the COVID-19 diagnosis. There is no prior authorization requirement to review for testing, meaning your doctor does not have to ask us for approval to test for COVID-19. Coverage is provided at no-cost at both in and out of network facilities. This policy will remain in effect for testing beginning on March 13, 2020, until the end of the Public Health Emergency.

Beginning on Jan. 15, 2022, Sanford Health Plan is covering the cost of up to eight at-home COVID-19 tests per calendar month per member. To be reimbursed for the cost of tests, members must submit a claim form along with an itemized receipt to Sanford Health Plan through USPS. Members can access the claim form at www.sanfordhealthplan.com/covid-19.

Treatment: Sanford Health Plan covers all treatments related to COVID-19 according to the cost share indicated in the member's plan. This includes home monitoring, inpatient admissions, and outpatient antibody treatments.

Can telehealth providers evaluate symptoms and send the individual for a COVID-19 diagnostic test?
A telehealth provider may determine whether the individual should receive a COVID-19 diagnostic test. The COVID-19 diagnostic test and test-related telehealth visit is paid at no cost share.

Will zero cost share be available for an employee that is required to remain outside of the country due to COVID-19?
Coverage for the test and test-related visits will be paid at zero cost share. The claim is processed by transaction accommodating the foreign exchange rate according to the terms in the member's plan.

Do coverage changes apply for the HDHP plans as well?
Yes. The Internal Revenue Service advised on March 11, 2020, that high-deductible health plans (HDHPs) can pay for 2019 Novel Coronavirus (COVID-19)-related testing and treatment, without jeopardizing their status. This also means that an individual with an HDHP that covers these costs may continue to contribute to a health savings account (HSA).

Does Sanford Health Plan cover antibody detection tests (Serology-IGG/IGM/IGA for SARS-nCOV2 (COVID19)?
Yes. During the national public health emergency period, Sanford Health Plan will cover FDA-authorized COVID-19 antibody tests ordered by a qualified physician without cost sharing (copayment, co-insurance or deductible).

An antibody test may determine if a person has been exposed to COVID-19, while a COVID-19 diagnostic test determines if a person is currently infected.

Does Sanford Health Plan cover antibody or COVID-19 tests as part of my return to work plans for my workforce?
No. Sanford Health Plan does not cover pre-employment screening. Sanford Health Plan will cover FDA-authorized COVID-19 diagnostic and antibody tests when ordered by a physician or appropriately licensed health care professional without cost sharing (copayment, co-insurance or deductible). We do not cover routine return to work screenings or tests administered before members are enrolled in our plans.

If a plan does not have out-of-network (OON) benefits, will Sanford Health Plan pay for COVID-19 OON care?
Yes, for a plan that doesn't have OON benefits but related to the COVID treatment during this COVID emergency period, Sanford Health Plan would pay at the network **(INN)** level including inpatient care.

If a member is tested for the flu and strep at the same time as COVID-19, how will the care be paid?
All diagnostic tests administered at the same time as a COVID-19 test for the purpose of identifying COVID-19 are covered at no cost to the member.

If a member is not feeling well and has some symptoms but is not tested for COVID-19 (for example they receive a flu test) and the visit and test are not coded as COVID-19, how will the care be paid?
The provider should bill for the services conducted. In this case there is no COVID-19 testing diagnosis or test codes billed or COVID-19 diagnosis code associated with the care, then it would be paid based on the members normal benefit plan and standard cost share applies.

Does Sanford Health Plan require a COVID-19 test claim to be present in order for a testing-related office visit claim to pay at no member cost share?
A COVID-19 diagnosis code or COVID-19 test code is required on the claim to waive cost share.

What is Sanford Health Plan's policy on telehealth services?
During the COVID-19 public health emergency, Sanford Health Plan was proud to support temporarily enhanced access for members to receive health care safely and conveniently. Now that we're starting to return to normal, generally, so will some of our previous practices.

On June 15, 2021, we moved away from the COVID-19 provision for Telehealth, meaning we will no longer cover Telehealth at $0 cost share for members.

What this means:

- All Telehealth will go back to "pre-COVID-19" coverage.
- If it was covered before, it will be covered now.
- If it wasn't covered before, it won't be moving forward.
- This will apply to all Telehealth services received on or after the June 15 deadline.

As a reminder, there are three virtual care options you and your employees can utilize. Learn more here.

Where can my employees find the latest updates regarding COVID-19 related benefits and coverage?
Members can visit sanfordhealthplan.com/covid-19 to view the latest information from Sanford Health Plan related to testing, coverage updates, FAQs and more.

What eligible expenses for FSA/HSA funds were recently added by the CARES Act?

1. Over-the-counter medication purchased Jan. 1, 2020, and after no longer requires a prescription to be an eligible expense for FSA/HSA funds.
2. Menstrual care products such as tampons, pads, liners, cups, and sponges purchased Jan. 1, 2020, and after are also eligible expenses.

Employees must submit reimbursement requests and receipts for these expenses manually while stores and vendors work to update their computer systems to automatically process benefits cards.

Those with FSAs can upload claims directly into the portal and avoid completing a claim form on either the MyHealthEquity.com portal or HealthEquity mobile app and follow a few easy steps to file your claim. Those with HSAs can make a normal distribution to their bank account on file from the portal.

Can my employees change their dependent care flex funds election due to daycare changes in response to COVID-19?
Yes. If an employee's daycare provider has closed due to COVID-19, or the employee is working from home and can provide their own care, the employee may change their election.

I am planning to change my employer contribution to employees' HSA funds. Will this require an amendment to the plan documents?
No, the plan documents do not specify the amount contributed to HSA funds by an employer. You may adjust this amount without amending the plan documents.

Premium and Payment Options:

Will there be any opportunity to pay my grace period on an installment plan?
Sanford Health Plan will work with individuals and employers during the COVID-19 Emergency Declaration to be more flexible in payment plans.

Eligibility Changes:

Is a furloughed employee eligible to stay on the plan?
Yes. If employers are furloughing employees, Sanford Health Plan allows flexibility in the plan eligibility definition as long as premium payments continue on the same basis as they currently do.

If employers have employees no longer meeting the hourly requirement for eligibility, can the employees stay on the plan?
If your group is temporarily reducing hours for employees, we're allowing flexibility in eligibility definition as long as premium payments continue on the same basis as they currently do. Employers define eligibility and can make that decision and pay the premium accordingly.

If employees are laid off, will they be eligible to stay on the plan or should they be changed to COBRA status?
If your group is terminating/laying off employees, COBRA applies. Individuals may obtain coverage on the Individual market, which may be subsidy-eligible based on income. At least one employee must remain on the group plan to maintain the policy.

How does COBRA coverage work?
COBRA is short-term insurance that's usually available for up to 18 months after a person's job situation has changed. Generally, a person could get COBRA coverage if they worked for a business that employs 20 people or more. With COBRA, individuals can continue the same coverage they had when they were employed. They cannot choose new coverage or change plans to a different one.

What does the recent guidance state on extension of COBRA coverage?
Due to the COVID-19 National Emergency, timelines used by group health plans for continuation coverage (COBRA) will disregard the period from March 1, 2020, until sixty (60) days after the end of the COVID-19 National Emergency (the "Outbreak Period"). This is being done based on a final rule issued by the federal health care agencies and impacts ERISA fully insured plans and self funded plans. The law does not apply to small groups with 1 to 19 employees (mini COBRA/state continuation). There is no ability to opt out of the requirements.

Final rule timeline impacts:

1. Covered employee, beneficiary or employer to give notice to a Plan that a qualifying event has happened;
2. Covered employee to elect continuation coverage under COBRA; and

3. Covered employee to make the required premium payments. Notice of Qualifying Event to Employer or Plan.

Currently, a covered employee must be given at least 60 days to give notice to a Plan that a qualifying event has happened. Employers have 30 days to give notice of a qualifying event to the Plan.

Under the final rule:

- The timeframe for the employee to give notice to the Plan has been extended to at least 60 days after the end of the outbreak period
- The timeframe for the employer to give notice to the plan has been extended to 30 days after the end of the outbreak period.

COBRA participants will be required to pay for months covered, even though payment may be deferred during the Emergency/Outbreak period. Premium would be due 30 days at end of Outbreak Period.

If a member elects COBRA coverage, will their policy be effective even if they don't make a payment?

If COBRA coverage was elected after March 1, 2020, coverage will be active even if the COBRA participant does not make payment. The rule applies to both fully Insured and self-funded plans.

Any payments deferred during the Outbreak Period, will need to be paid in full within 30 days of the end of the outbreak period as outlined in the notice.

How can a person get health insurance if they don't qualify for COBRA?

They may be able to get coverage through the Marketplace. It may also cost less than COBRA continuation coverage. There are special enrollment periods available if when the job situation, such as loss of job or fewer hours resulting in no benefits, has caused the person to lose coverage.

Through the Marketplace, they may qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP).

The person can also compare costs to see if a short-term insurance plan would work for their needs. Standard short term health insurance plans can help fill a gap in coverage from one month to just under one year.

Can employers waive their current new hire waiting period during this time?

Yes. Sanford Health Plan is allowing employers to make contract changes to shorten waiting periods. For example, an employee hired Feb. 1 with a typical 90-day waiting period could be changed to a 60-day waiting period, making the employee effective April 1. Waiting periods can still not be extended past 90 days.

Can an employer keep a policy active if there are no employees actively working?

No. If your group is terminating coverage (no active employees/closing business), standard contract termination provisions apply. In this case, COBRA does not apply. Individuals may obtain coverage on the Individual market, which may be subsidy-eligible based on income.

Can employers waive new hire waiting period for rehires?
Yes. The period of time allowed between an employee's termination date and rehire date allowing the new hire waiting period to be waived is determined by the employer's eligibility rules. If an employer would like to increase this period of time (i.e. from 30 days to 90 days) they should do this by adjusting their eligibility rules.

Will Sanford Health Plan honor any Special Enrollment period allowing employees to come on that previously waived, or if anyone wants to add dependents?
Yes. Sanford Health Plan will honor any eligibility changes an employer offers to further extend coverage for uninsured individuals. Eligibility rules are controlled by the employer group.

Is the Special Enrollment Period (SEP) compliant with Section 125 Premium Only Plans?
Recent guidance (Notice 2020-29) allows mid-year election changes to section 125 cafeteria plans, FSAs and some other relief. The Notice provides tax certainty to groups that held enrollment opportunities recently to allow their employees to make changes to enroll in an employer health plan or change an existing enrollment outside of the annual enrollment period.

If employers have an employee who requests an unpaid leave of absence and does not pay their share of premiums, resulting in termination of their coverage, are they able to automatically re-enroll when they return?
It depends. If the period between termination and rehire is under 13 consecutive weeks, no new offer of coverage is needed. If the period between termination and rehire is beyond 13 consecutive weeks, employers can treat employees as a "new hire" and impose waiting periods and such.

Administration Changes:

Do employers need to send updated applications or documentation about eligibility changes?
Not at this time. Sanford Health Plan understands the need for flexibility in these times of constant change and does not need additional documentation at this time to implement any eligibility changes.

Will a customer lose grandfathered status if they adopt COVID plan changes?
COVID plan changes to provide greater coverage related to the diagnosis and/or treatment of COVID-19 such as waiving cost share for COVID-19 testing and related office visit, treatment, and telehealth will not cause a plan to cease to be a grandfathered health plan, provided that no other changes are made that would cause a loss of grandfathered status.

Will there need to be any amendments made to plan documents to reflect the change in COVID-19 coverage or telehealth?
No changes are planned or required at this time. Members can find up to date coverage and cost-sharing changes at www.sanfordhealthplan.com/covid-19.

Federal Updates:

What information can you provide on the Federal Legislation that passed on March 18, 2020?
The Families First Coronavirus Response Act (HR 6201) ("Act") requires group health plans and health insurance issuers offering group or individual health insurance coverage (including grandfathered plans) to cover COVID-19 testing and certain COVID-19 testing related items and services without cost sharing (deductibles, copayments and coinsurance), prior authorization or other medical management requirements.

- This coverage includes the COVID-19 diagnostic test and a COVID testing-related visit to order or administer the test. A testing related visit may occur in a health care provider's office, an urgent care center, an emergency department or through a telehealth visit.
- For plans with in- network and out-of- network benefits cost sharing (copayments, coinsurance and deductibles) will not apply.
- For plans with in-network benefits only, cost sharing (copayments, coinsurance, deductibles) will not apply for out-of-network emergency services or when an in-network provider is not available.
- Telehealth services apply both in and out-of-network.
- The Act is effective March 18, 2020, to apply retroactively. Sanford Health Plan has adopted these guidelines and is re-adjusting claims to back to March 13, 2020, to be compliant with the March 18 effective date.