Trustmark
benefits beyond benefits

Help for Customers Affected by the Coronavirus

Plan Design Changes and Plan Administration FAQ

Revised June 2020

Small Business Benefits

The health and wellbeing of our associates and customers are our top priorities. We understand that the toll of COVID-19 goes well beyond the impact of the illness itself. Here, we want to share health benefit plan design changes and offer answers to commonly asked questions related to plan administration and the pandemic.

Plan Design Changes

Please note: **As we previously communicated to employer-sponsored health benefit plans administered by Star Marketing & Administration Inc., the following plan design benefit changes apply:**

The Coronavirus Aid, Relief, and Economic Security (CARES) Act

On March 27, 2020, the President signed The Coronavirus Aid, Relief, and Economic Security (CARES) Act in response to the COVID-19 pandemic that amended the Families First Coronavirus Response Act, which was enacted nine days earlier. Here are some highlights of the CARES Act that impact self-funded group health benefit plans:

Coverage for COVID-19 Testing without Cost Share

Individual and group health plans, including both fully insured and self-funded, **must cover COVID-19 diagnostic testing**, whether or not that testing is FDA-authorized. This provision is an update of the previous stimulus package that required coverage for FDA-authorized tests only.

Payment Amount for COVID-19 Testing

Self-funded group health plans and insurance carriers must pay the provider making the diagnosis of or testing for COVID-19 at an **amount equal to the in-network negotiated rate** for the testing and/or diagnosis of COVID-19. If the carrier or self-funded group plan does NOT have a negotiated payment rate, or does not then negotiate a specified price with the provider, the benefit amount should equal the cash price of the service or product that is posted on the provider's publicly available Internet site.

No Required Payment for COVID Treatment

This legislation does NOT require coverage for *treatment* of COVID-19 (only for testing and administration of such testing). Benefits for the treatment of COVID-19 will be administered in

accordance with the terms of the health benefit plan document.

Coverage for COVID-19 Vaccine without Cost Share
Once a COVID-19 vaccine is developed and "recommended" as a preventive service, insurance carriers and self-funded plans **must cover the cost of the vaccine without any cost-sharing.** This requirement would go into effect 15 business days after the U.S. Preventive Service Task Force rates it an "A" or "B" or after it is recommended by the Advisory Committee on Immunization Practices of the CDC.

HSA-Eligible HDHP Exemption for Telehealth
An HSA-eligible HDHP is temporarily allowed to pay for the costs associated with a telehealth visit before the deductible is met. The member would also continue to be eligible to make tax-free contributions to their HSA. This exemption is only available for plan years beginning on or before Dec. 31, 2021.

FSA, HRA, HSA Reimbursement for OTC Drugs, Feminine Hygiene Products
Prescriptions for over-the-counter medicine are no longer needed to obtain reimbursement from flexible spending accounts (FSAs), health reimbursement arrangements (HRAs) and health savings accounts (HSAs). In addition, feminine hygiene products were added to the list of eligible expenses. These changes became effective for eligible purchases made on or after Jan. 1, 2020.

In addition to mandated benefit changes from the new federal laws, we previously announced telemedicine benefit changes to health benefit plan designs administered by Star Marketing & Administration, Inc. We are extending the telemedicine plan design changes through groups' next renewal date, and the changes become permanent for new plan years beginning on or after 12/1/20. For example, a group with its next renewal occurring on 8/1/20 will have these benefits extended through 7/31/21. On 8/1/21, these benefits become a permanent part of the plan design.

Contact your Account Manager at 800.522.1246, ext. 35382, by June 30, 2020, if you do not want your current health benefit plan to continue to offer the two bulleted benefit changes regarding telemedicine.

- **Teladoc®:** The consult fee for Teladoc telemedicine services will be $0 for members, with applicable costs paid by the plan. Teladoc provides covered employees and their dependents with access to a U.S. board-certified doctor through the convenience of phone and video consults for non-urgent care.
- **Claims for virtual care/telemedicine visits with any non-Teladoc doctor, such as your primary care physician:** Except for the testing mandate as explained above, these claims other than COVID-19 testing-related claims will be processed as a physician office visit in accordance with your plan's provisions. Copays or deductibles will apply, if applicable.

Early refills of prescriptions
Early refills of prescription drugs were allowed until June 15, 2020, to ensure an uninterrupted supply. Some drugs may have been prohibited from early refills by federal regulations.

HDHPs Can Cover Coronavirus Costs
The IRS announced that high-deductible health plans (HDHPs) can pay for COVID-19-testing and treatment prior to meeting the deductible, 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).

Please contact your Account Manager who is ready to assist you with any questions.

Plan Administration FAQ

Please note: **The accommodations listed below will be made upon *written request via email* to AccountManagementSB@trustmarkbenefits.com and will be in effect through Sept. 30, 2020, unless otherwise noted. If you previously requested any of these accommodations, you do not need to request them again.**

Can there be any extension of the grace period?
Yes. We can grant up to 30-days' additional grace period on administration fees, stop-loss premium and benefit plan claim funding. Please note, during such extension, we will stop administering all claim payments until employers remit the full invoiced amounts that are due.

Is a mid-year plan change (buy-down) an option in order to reduce monthly cost?

Yes. Until June 30, 2020, mid-year plan changes can be considered for groups once per year. Groups in their first year need to stay in the plan family (for example, a PPO plan cannot switch to a non-PPO plan.) If moving to a plan design with a lesser benefit, an employer is required to provide 60-days notice to covered employees or can waive that notice in writing. Please contact your Account Manager for details.

If an employer lays off a covered employee, can the waiting period for the plan year be waived?
Yes. According to a provision in the Conditions of Coverage section of the plan document, if an employee loses coverage because of a layoff or leave of absence of no more than six months, the employee can rejoin the plan on the first of the month after he or she returns to work.

Will hourly requirements for determining eligibility be enforced? What if a company wants to continue coverage but enrolled employees no longer meet the minimum hourly requirement?

Employers currently notify us when employees are no longer eligible (working at least 25 hours per week) or are no longer covered under the plan. Some employers may have employees working fewer hours, temporarily on leave/laid off or furloughed. Employers may maintain these employees and their dependents on the plan provided all payments continue to be made for them. New hires should follow normal guidelines. They need to meet the waiting period and work the minimum number of hours determined by the employer (which is normally higher than 25 hours).

What if the employer has to lay off the entire workforce?
If an employer's workforce is laid off due to the pandemic, as long as one covered employee remains on the plan and all administrative fees, stop-loss premium and claim funding for the one employee and laid off employees are paid, we will continue to administer the plan in accordance with the plan document and the stop-loss insurance contract will not be terminated due to a drop in enrollment.

Can we extend the Open Enrollment period at renewal?
Yes. While the clients' plan documents state the Open Enrollment period is 30 days prior to the plan's renewal date, we can accommodate customers by providing up to an additional 30 days from the effective date to complete open enrollment.

What are my COBRA requirements?
COBRA generally requires that group health benefit plans sponsored by employers with 20 or more employees in the prior year offer employees and their families the opportunity for a temporary continuation of health coverage (called continuation coverage) in certain instances where coverage under the plan would otherwise end. For more information, please visit https://www.dol.gov/general/topic/health-plans/cobra for an FAQ and information on COBRA assistance.

If a member has already met part or all of his or her deductible before a layoff, goes on COBRA, and then is re-hired – would the deductible met to date flow to COBRA and back to the group coverage upon re-hire?
Since COBRA is essentially a continuation of coverage, COBRA members will continue to have the same benefits and out-of-pocket-accumulations while they are on COBRA. As long as there is no break in coverage between COBRA and the re-hire date, the coverage and out-of-pocket expenses would continue to accumulate as if there were no break in coverage.

If an employer lays off their workforce and a member doesn't take COBRA, would the amount that satisfied the member deductible remain when the member is re-hired?
Yes. Deductibles and out-of-pockets met in a previous part of the same plan year will still be credited for rehires.

Will any renewal actions be delayed?
We do not anticipate delays or changes at this time. We strive to provide renewals in the same timely manner we always have. Groups that need more time to decide if they wish to renew should talk to their Account Manager.

Can a group that drops below five lives at renewal have the opportunity to renew coverage?
Inforce groups that wish to begin a new plan year and that dropped below five lives at renewal because of layoffs due to the pandemic should discuss the situation with their Account Manager.

Can the employer suspend administrative services and stop-loss coverage and restart with the same covered employees at a later date without new underwriting requirements?
If the group no longer has any active plan members, the administrative services and stop-loss coverage will be terminated. Termination of member's coverage under the plan will trigger a Qualifying Life Event for the members to seek coverage through the healthcare marketplace during a Special Enrollment Period as part of the Affordable Care Act. Reinstating recently terminated services and stop-loss coverage should be discussed with your Account Manager.

If a group is in financial hardship, would we consider issuing a refund prior to the end of the run-out period?
Surplus refunds will be made in accordance with the settlement option chosen by the plan sponsor. Earlier release of funds is not possible, as they are held to make sure claims incurred during the plan year can be paid.

Will you modify rates for changes in enrollment greater than 10 percent?
We will not modify rates mid-year when changes in enrollment are due to the pandemic.

Can an employer self-adjust their payments due to enrollment changes?
Employers should avoid adjusting their regular monthly payment to ensure claims continue to be paid.

Remember: **Accommodations listed above will be made upon *written request via email* to AccountManagementSB@trustmarkbenefits.com and will be in effect through Sept. 30, 2020, unless otherwise noted. If you previously requested any of these accommodations, you do not need to request them again.**

We're closely watching the decisions in Washington, D.C., and at the state level as this situation continues to evolve. COVID-19 claims are processed in compliance with all applicable federal and state laws.

Your plan documents provide useful information regarding plans provisions and are conveniently located in the Document Center at TrustmarkSB.com. Employers should consult with their legal counsel and/or tax advisor to determine if their benefits meet applicable state and federal requirements.

Trustmark Small Business Benefits®

Plan design availability and/or coverage may vary by state. Self-funded plans are administered by Star Marketing & Administration, Inc., and stop-loss insurance coverage is provided by Trustmark Life Insurance Company.

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