COVID-19

Updates + Frequently Asked Questions

Supporting our partners and members
March 7, 2023

Many of you have questions about COVID-19 – from prevention to coverage for testing, treatment, and vaccines. We can help you stay informed with current information and answers to some of the frequently asked questions.

Go to COVID-19 Resources for Employers for information and resources available to support you, your employees, and their families. If you have additional questions not answered in this document, please contact your Medica representative.

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COVID-19 vaccine coverage and availability

Are the vaccines safe and effective?
Yes. The vaccines went through extensive safety and clinical trials, reviewed by the Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC). Numerous vaccine trials have taken place around the world and included voluntary participants from a variety of races, ages, ethnicities. The vaccines are safe and effective, with up to a 95% success rate in offering protection from COVID-19.

Which vaccine is available to me?
Vaccines for COVID-19 are widely available and Medica members of all ages are encouraged to receive their vaccine. Most vaccines consist of a series of two shots, about one month apart. You need to get both shots to receive full protection from COVID-19.

Do I need the COVID-19 booster?
COVID-19 vaccine boosters are now available and an important way to help prevent COVID-19. Check with your health care provider about available COVID-19 boosters.

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I'm healthy and at low-risk for COVID-19. Do I need the vaccine?
Yes. COVID-19 doesn't discriminate. Even young, healthy people can catch the virus and struggle with severe complications. Getting more people vaccinated will offer the greatest protection for all.

How is the cost of the COVID-19 vaccine covered?
We will waive costs for the vaccine and administration of the vaccine for all members. You can get the vaccine at various in-network and out-of-network retail pharmacies, doctor's offices, and hospitals.

Here are some helpful resources that offer up-to-date COVID-19 information:
CDC COVID-19 website
CDC COVID-19 FAQs
CDC COVID-19 vaccines
CDC COVID-19 vaccine guidelines

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COVID-19 coverage for testing and treatment

What is the coverage for COVID-19 testing, treatment, and associated services?

1. **COVID-19 tests are covered with no member cost through May 11, 2023 for all Medica members**. - *Updated on 3/7/23*
   This includes copays, co-insurance, and deductibles for office visits, drive-through test sites, urgent care and emergency room visits associated with COVID-19 testing. Tests must be FDA-issued, medically necessary, and ordered by an in-network medical professional with a diagnosis of COVID-19 or suspected COVID-19.

   If COVID-19 testing takes place at an out-of-network provider, all other services associated with the out-of-network provider will be covered at the out-of-network benefit, including, but not limited to influenza tests, blood draws, strep test, chest x-ray, etc.

   COVID-19 tests are not covered as part of a return-to-work requirement, public surveillance program, or travel requirement.

How can members order free at-home COVID-19 diagnostic test kits from Express Scripts?
Members can order up to eight at-home antigen COVID-19 test kits from Express Scripts, Medica's pharmacy benefits administrator, for each member per month covered under a subscriber's plan. Members can sign in to **Medica.com/SignIn**, go to the *Prescriptions* section, select *Go to your Express Scripts* website and choose *Order at-home COVID-19 tests*.

Are at-home over-the-counter (OTC) COVID-19 diagnostic test kits covered?
Effective Jan. 15, 2022, and for the duration of the national public health emergency, Medica members enrolled in individual plans and commercial fully and self-funded plans have coverage for OTC FDA-authorized COVID-19 antigen tests without a prescription from a qualified health professional.

- Coverage includes up to eight FDA-approved OTC COVID-19 antigen home tests for each member per month covered under a subscriber's plan.
- Tests can be obtained through a network pharmacy or mail order at no cost using your Medica ID card.* Tests should be brought to the pharmacy counter to be submitted through the claims process.
- If you purchase the test through a retailer (e.g., at the front register), you will be charged the full cost of the test and will need to submit a claim form to be reimbursed. Reimbursement will be $12 per OTC test.
- Tests obtained at an out-of-network pharmacy or retailer are eligible for reimbursement at $12 per OTC test. Members will be required to submit a claim form to process reimbursement.
- Tests purchased to fulfill employer-directed testing requirements are not eligible for reimbursement.

*If members paid out-of-pocket for their OTC antigen tests, they will need to submit a request to get reimbursed for their costs.

To submit your reimbursement request online:
- Sign in to **Medica.com/SignIn**
- Go to the *Prescriptions* section and select *Go to your Express Scripts website*
- Click on *Benefits* and select *Forms*
- Go to *Request reimbursement* and click *Start a Claim*

To submit your reimbursement request by mail or fax:

- Complete the Pharmacy Claim Submission form (Note: you don't need to enter the NCPDP/NPI information or have the form signed by the pharmacy)
  Mail your completed form and receipt(s) to:
  Express Scripts
  ATTN: Commercial Claims
  P.O. Box. 14711
  Lexington, KY 40512-4711
- Or fax your completed form and receipt(s) to **1-608-741-5475**.

A listing of FDA-approved Emergency Use Authorization (EUA) COVID-19 antigen tests can be found on the FDA's website.

What is the difference between PCR and antigen COVID-19 diagnostic tests?
A PCR (or Polymerase Chain Reaction) test is used to detect genetic material from a specific organism, such as a virus. PCR tests detect viral RNA. PCR tests are sent to a lab for the assessment of the test. Results generally take a couple of days.

Antigen tests, also called rapid diagnostic tests, detect specific proteins on the surface of the coronavirus. Antigen tests can be purchased through a retailer and done at home. Results may come back in as little as 15 to 45 minutes.

2. **COVID-19 antibody tests are covered with no member cost for FDA-approved tests through May 11, 2023.** - *Updated on 3/7/23*
   The test must be medically necessary and ordered by an in-network medical professional. Antibody testing is not covered as part of a return-to-work requirement without meeting other criteria.

3. **COVID-19 monoclonal antibody treatment is covered with no member cost through April 30, 2023**. - *Updated on 1/20/23*
   Treatment must be medically necessary and ordered and received by an in-network medical professional. Coverage includes medications under emergency use authorization by the FDA including Eli Lilly (Bamianivimab and Bamlanivimab & Estesevimab) and Regeneron (Casirivimab and Imdevimab). Recommendations for these products are frequently changing. Speak with your provider about current treatment recommendations. Some self-insured employers may not include antibody treatment coverage.

4. **Telehealth/virtual health services are expanded through May 31, 2023.** - *Updated on 3/7/23*
   And now includes technologies such as FaceTime or Skype, and audio only, for most visits, when video is not available. This coverage applies to all fully insured groups, self-funded groups, individual, Medicare, and Medicaid members. Telehealth services are covered under the member's benefit plans.

How are COVID-19 oral treatment drugs covered?
COVID-19 oral treatment drugs will be included in the preferred brand tier on Medica's Drug List. During the national public health emergency, members will not be responsible for the ingredient cost of the COVID-19 oral treatment drug. Members will pay approximately $6 or their preferred brand copayment, whichever is less. After the national public health emergency ends, members will be responsible for their preferred brand copayment.

If a self-funded customer elects to expand COVID-19 coverage, will the claims apply to stop loss?
Yes, claims related to COVID-19 will apply to stop loss.

Are virtual care services available?
Virtual care is a convenient way for members to get care for many common medical conditions by connecting with a provider from their computer or mobile device from home, work, or wherever they are. Although confirmation and testing of COVID-19 cannot be done via virtual care, members experiencing symptoms can get help assessing risk and receive recommendations on next steps.

How members can access virtual care:

- Check with their clinic to see if virtual care is available and learn how to connect with their provider online.
- Access virtual care through **Amwell**, a 24/7 online clinic available in all states.
- Check other virtual care options that may be available through their plan's network, such as Virtuwell, at **Medica.com/FindCare**. Select your plan and click on "Virtual care."

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Continuing coverage

What options do employees have if they lose their group plan coverage?
For employees who lose their group plan coverage, they have options including:

- Continue on employer's plan through Continuation/COBRA
- Enroll in an individual plan through an insurance carrier like Medica
- Enroll in a Medicare plan through an insurance carrier like Medica (employee must be eligible for Medicare)

Learn more about Continuing Your Health Insurance options. For Medica Individual and Family coverage options, call **1-800-670-5935**.

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Timeline extensions

How are these deadlines determined while the Notification of Relief is in effect?
With the March 2020 declaration of a national emergency, the U.S. Department of Labor and the Internal Revenue Service (IRS) released the *Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak.* This notification of relief requires group health plans to disregard the "outbreak period" when calculating special enrollment deadlines. The outbreak period started March 1, 2020 and extends to the date 60-days following the end of the national emergency or such other date announced by the DOL and IRS.

More specifically, group health plans must disregard the outbreak period when determining the following periods and dates:

- 30-day period allowing enrollment due to loss of other coverage, or life events such as marriage, birth, adoption, or placement for adoption.
- 60-day period allowing enrollment after loss of CHIP or Medicaid coverage.
- 60-day election period for COBRA continuation coverage and premium payment.

It is the employer's responsibility to determine and manage their plan's eligibility and enrollment in a manner consistent with general COBRA provisions and the Notification of Relief. Medica understands that employers may find that administering this Notification of Relief may lead to additional requests for retroactive adjustments to enrollment for COBRA recipients. If a member makes a COBRA premium payment that is considered timely under the Notification of Relief, Medica will process an employer's request for retroactive enrollment or re-enrollment even if the requested enrollment date is retroactive to beyond 60 days from the date of the employer's request. Please refer to the Group Administrator Guide for additional general information on processing COBRA enrollment changes. Additionally, Medica encourages you to consult with your COBRA administrator or other benefit advisor(s) to discuss any specific questions you may have.

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