PUBLIC SESSION MINUTES
EMPLOYEE BENEFITS ADVISORY COMMITTEE MEETING
THURSDAY, SEPTEMBER 03, 2020

A meeting of the Employee Benefits Advisory Committee was held at 11:00 a.m., Thursday, September 03, 2020, virtually via the Microsoft Teams Meeting application.

MEMBERS PRESENT: Councilmember Kevin Thompson, John Pombier, Mary Cameli, Amy Trethaway

MEMBERS EXCUSED: Councilmember Mark Freeman

OTHERS PRESENT: Teri Overbey, Human Resources Director
Janice (Jan) Ashley, Employee Benefits Administrator
Cecilia Damron, Assistant Employee Benefits Administrator
Alicia White, City Counsel Assistant
Erica Navarro, Employee Benefits Supervisor - Secretary

The meeting was called to order at 11:07 a.m. by Councilmember Thompson

Agenda Item #1: Hear a presentation, discuss, and provide direction on Summary of Health Plan Document Change Recommendations for 2021

- Jan Ashley provided an overview of the Summary of Changes to the City's Health Plan Document Summary Plan Description for calendar year 2021 and answered questions for the Committee.
- The recommended changes include:

    - **Language updates and corrections**: Schedule of Medical Benefits and Exclusions sections updated to remove exclusion on virtual office telephonic and video professional medical and behavioral health services provided by independent Physicians and Health Care Practitioners. Under current standards of care these services are covered at usual benefit levels by Plan, in addition to specifically contracted Telehealth service providers (consolidated to MDLive for Cigna in 2021).
    - **Language updates and corrections:** Medical Schedule of Benefits Section simplified to reaffirm that Fertility and Infertility Services remain not covered. Medical Exclusions section has been updated regarding Fertility/Infertility Services that are not covered and Definition of Infertility has been added to Definitions section of the document for further clarity around when an infertility diagnosis is clinically deemed to apply.
    - **Language updates and corrections**: Clarification of in-network benefit levels for out-of-network ancillary service providers in conjunction with primary services by in-network providers and facility, to include both elective surgical/diagnostic procedures and preventive surgical/diagnostic procedures e.g. OON anesthesiologist at preventive in-network colonoscopy or endoscopy procedure. Language also highlights balance billing potential, regardless of in-network benefit levels due to potential differences between billed charges and allowable charges.
    - **Language updates and corrections**: Dental Schedule of Benefits clarification on necessity to be enrolled in Dental Choice Plus Plan (the only plan that provides Orthodontia coverage), during the entire period that annual orthodontia coverage claims are paid by the Plan (up to 2 years), concurrent with orthodontia banding services and subsequent care delivery.
    - **Plan Enhancements:** Vision Plan Schedule of Benefits reflects increases in plan allowances (or benefits) under newly awarded insurance contract with VSP, for all three plan options: out-of-

network Exam allowance increased from $45 to $70 (from July 1, 2020); in-network frame allowance up to $170 (from $150) and $190 for featured frames (from $170); Costco/Sam's Club/Walmart frame allowance up to $95 (from $80); in-network contact lenses allowance up to $220 (from $200); Plus and Premium Plus plans provide standard allowance frames purchases in same year as contact lenses purchase (instead of "in lieu" purchases, as remains in the Basic Vision Plan).

- **Compliance Requirement:** Schedule of Medical Benefits updated to reflect CARES Act requirement to provide 100% coverage in and out-of-network for Covid-19 related testing, vaccines and services, physician, urgent care, telehealth and emergency room settings. In network Covid-19 hospital services 100% covered during declared health emergency periods – end point as yet to be determined.
- **Compliance Requirement:** Special Enrollment, Claims and Appeals and COBRA continuation sections updated to reflect various timeframe extensions in response to national declared health emergencies. Sample of COBRA update included: "The federal Department of Labor, Department of Treasury and with concurrence of Department of Health and Human Services issued guidance/relief in April, 2020 that provides timeframe extensions to deadlines otherwise in place for COBRA administration actions, in response to declared national emergency periods ("Outbreak Period"). The Outbreak Period began on March 1, 2020 and will end 60 days after the announced date of the end of the declared national emergency related to COVID-19 (to be advised). Under the relief, the Outbreak period timeframe must be disregarded in calculating the timeframes that apply to COBRA elections and premium payments."
- **Compliance Requirement:** Flexible Spending Account - Health FSA section aligned with IRS guidelines to allow increased maximum election amount for 2021, rollover amount increase and changed rules on reimbursement of over-the counter drugs/supplies to provide enhanced member benefit and increased potential FICA cost savings for the City; similar IRS approved deadline extensions for claims and substantiation filings in response to national health care emergency situations.
- **Compliance Requirement:** Flexible Spending Account – Dependent Care section aligned with IRS guidelines to accommodate child care events that have resulted from national health emergency, school closures and greater frequency of telecommuting and remote work activities; similar IRS approved deadline extensions for claims filings in response to national health care emergency situations.

- Mary Cameli asked what are preventive services that might be included in ancillary benefit in-network benefit levels?
- Jan Ashely provided the example of a colonoscopy. Colonoscopies are recommended preventive services for age group 50-75 every 5 years (subject to change as standards of care protocols change), when no medical condition of the colon is known at the time the preventive colonoscopy is scheduled. The colonoscopy will turn into a diagnostic colonoscopy if the claim is coded as such and if a medical condition is diagnosed and/or treated during the otherwise preventive screening procedure. This is further complicated by the possibility of unexpected out-of-network ancillary services providers like anesthesia in conjunction with in-network primary provider and in-network use of a facility.
- Mary Cameli asked will Covid-19's long term health effects be covered at 100%?
    - Jan Ashley replied no, treatment for Covid-19 long term effects will fall under regular plan benefit coverage (deductible and co-ins will apply).
- John Pombier asked if an emergency room visit in North Carolina would be covered in-network?
    - Jan Ashely replied if the service was of an emergent nature and coded accordingly yes, it would be covered in-network. There would be no guarantee that balance billing would not occur.

- Councilmember Thompson asked how does a member know which insurance to use for medical services of the eye (conjunctivitis/pink eye)?
    - Jan Ashley replied that our vision care plan covers routine annual eye exam/screenings (including refractions) plus vision correction supplies like glasses, contacts etc. Many vision plan in-network providers are Optometrist credentialed with some Ophthalmologists as well. Both of these credentials are qualified to provide routine and some or all medical eye care services. However, the vision care plans limit coverage to one routine eye care exam each year and vision correction supplies. It is generally preferable to have all medical eye care and treatment processed under the medical plan benefit which provides coverage for medical conditions of the eye (illness, injury, infection or disease) just like any other medical condition. The medical plan network of providers is not the same as the vision plan network, especially with regard to Optometrists. A member who wants to use their vision plan in-network provider for medical eye services should check if that provider is in their medical plan network and be sure to file the claim under the medical plan benefit rather than the routine vision care benefit. If the vision provider is out-of-network, the claim can still be filed under the medical plan, but it will be subject to OON benefit levels that include a $1,500 deductible.
- Councilmember Thompson motioned to adopt Agenda Item #1 Plan Document recommended changes. Mary Cameli seconded the motion, and all were in favor. The vote was unanimous.
- Amy Trethaway motioned to adjourn the meeting. Mary Cameli seconded the motion, and all were in favor. The vote was unanimous.

The meeting was adjourned at 11:31 a.m.

Prepared by: Erica Navarro, Secretary to the Board