2021 Plan Document Change Recommendations Summary

Plan Document Page	Heading/Topic	Current 2020 Language/Policy	Recommendation for 2021 Language/Policy	Reason for Change	Category
5, 58, 147	**Virtual Office/Telemedicine Services**	Excluded virtual office professional medical and behavioral health services, except for services provides through specifically contracted Telehealth service providers; Telehealth service providers included Amwell for Cigna and MDLive for Cigna.	Removed exclusion on Virtual Office professional medical and behavioral health services provided by independent Physicians and Health Care Practitioners - these services covered at usual benefit levels by Plan, in addition to specifically contracted Telehealth service providers (consolidated to MDLive for Cigna in 2021).	Conform to medical practice standards for professional services in a virtual office visit setting, significantly enhanced in response to national health emergency standards; consolidation of specifically contracted Telehealth services with Cigna/MDLive for medical, behavioral health and wellness screening virtual visits.	Language Updates
44, 60, 135	**Fertility/Infertility Services**	Fertility and Infertility Services or Treatments - not covered post diagnosis.	Fertility and Infertility services or treatments are not covered. See Medical Exclusions and Definitions Sections for more information. **Fertility Services Exclusions:** a.Expenses for any services (including but not limited to, professional, lab, radiology, surgical, drug and ancillary) to determine the cause of infertility or for the treatment of infertility and complications thereof, including, but not limited to, services, drugs and procedures or devices to achieve fertility; in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor semen, cryostorage of egg or sperm and reversal of sterilization procedures.	Fertility and Infertility Services remain not covered; Plan Document language has been simplified in the Medical Schedule of Benefits Section to reaffirm that status. 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

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63	**Exceptions to Normal Plan Reimbursements for Non-Network Providers**	The patient had no choice of ancillary services provided by non-network provider(s) in conjunction with elective primary services performed by network provider(s).*	The patient had no choice of ancillary services provided by non-network provider(s) in conjunction with elective or preventive primary services performed by network provider(s).*	Clarification of in-network benefit levels for out-of-network ancillary service providers in conjunction with primary services by in-network providers and facility for both elective surgical/diagnostic procedures and preventive surgical/diagnostic procedures e.g. OON anesthiologist 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
72	**Schedule of Dental Benefits**	No specific language - although plan benefits paid as indicated in 2021 language.	Must be enrolled in the Choice Plus Plan in each calendar year in which yearly or lifetime Orthodontia maximum benefits are covered/paid.	Clarification on necessity to be enrolled in Dental Choice Plus Plan during the entire period that annual ortho coverage maximums are covered by the Plan (up to 2 years), concurrent with the receipt of Orthodontia services.	Language Updates
77 - 78	**Schedule of Vision Benefits**	2020 Schedule of Vision Benefits	2021 Schedule of Vision Benefits - with allowance enhancements in all three plan designs: Basic, Plus and Premium Plus	Out-of-network Exam allowance up $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.	Enhancement
34 - 35, 43, 46, 49	**Schedule of Medical Benefits - Covid-19 Updates**	Schedule of Medical Benefits sections on Hospital Services, Physician Services, Emergency Services and Laboratory Services	Schedule of Medical Benefits sections on Hospital Services, Physician Services, Emergency Services and Laboratory Services	CARE Act requirements to provide 100% coverage in and out-of-network for Covid-19 related testing, vaccines and services in , physician, urgent care, telehealth and emergency room settings. In network Covid-19 hospital services 100% covered during declared health emergency periods.	Compliance

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19, 94, 105	**Special Enrollment, Claims and Appeals and COBRA Continuation Sections**	Various timeframes for notice, elections and payments as may apply.	Various timeframes for notice, elections and payments as may apply, with federally mandated timeframe extensions in response to national declared health emergency.	Sample COBRA continuation section language: COBRA NOTICE, ELECTION AND PAYMENT TIMEFRAME EXTENSIONS DURING DECLARED NATIONAL EMERGENCY PERIODS: 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
115 - 117	**Health Flexible Spending Account (HFSA) - Maximum Election and Maximum Rollover Increases; OTC coverage without prescription**	Annual maximum election: $2,700; rollover maximum $500; over-the-counter medications and supplies require prescription or letter of medical necessity; Health FSA claims filing and substantiation period following calendar year end is March 31.	Annual maximum Health FSA election: $2,750; rollover maximum from 2021 to 2022 = $550; OTC medications and supplies for medically necessary purposes do not require a prescription or letter of medical necessity to be reimbursable under Health FSA effective retro to 1/1/20; rollover filing and substantiation deadlines extended past March 31 of the following calendar year subject to IRS approvals in any calendar year e.g. 2020.	Align maximum election amount, rollover amounts and OTC rules with most recent IRS guidelines 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 reaction to national health care emergency situations.	Compliance

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118 - 119	**Dependent Cares Flexible Spending Account (DCFSA) - qualifying event change types expanded/notification deadlines.**	Notify of Qualifying Event within 31 days. Dependent Care FSA claims filing and substantiation period following calendar year end is March 31.	Provide claims submission and substantiation for preceding calendar year by March 31 or later if approved by IRS in any calendar year e.g. 2020. Notify of qualifying event within 31 days or longer if approved by IRS regulations in any calendar year e.g. 2020. Expansion of qualifying event types.	Align with IRS regulations to accommodate child care events that have resulted from national health emergency, school closures and greater frequency of telecommuting and remote work activities: expansion of qualifying event types to include "an event change that is consistent with a change in cost of dependent care coverage, including but not limited to: increase/decrease in the cost of care as a result of moving from one child-care center/provider to another with different rates; increase or reduction in the hours (and cost) of care provided; decreases in cost (up to and including $0), due to care being provided at no charge by relatives, older siblings, telecommuting employee/spouse or other stay-at-home individual)".	Compliance