

MEMORANDUM

April 16, 2020

TO: Mayor John P. Kahl and Members of City Council

FROM: City Attorney's Office (Scott A. Brunton)

SUBJECT: Resolution Regarding Revisions to the City's Group Health Care Plan
(Effective May 1, 2020)

DISCUSSION:

As part of the City Insurance & Benefits Committee's annual review of the City's Group Health Care Plan (the "Plan"), the Insurance & Benefits Committee also reviews the Plan document to ensure that it is up-to-date and appropriately addressing current issues affecting the Plan. With the proposed change in the utilization management service provider to Precedence, the Plan document requires revision to properly reference Precedence in relation to specific services addressed in the Plan document. Additionally, the Insurance Committee is recommending revisions to the preventive care benefits providing coverage for mammograms and colonoscopies to ensure better health of Plan participants, which will also provide long-term savings to the Plan and Plan participants while encouraging participants to utilize these preventative measures.

Last, this Resolution approves and ratifies a Plan amendment that was approved by the Mayor on an emergency basis that addresses Plan benefits and reinsurance coverage during the current COVID-19 pandemic crisis. This COVID-19 Plan amendment will only be effective through the end of 2020 (December 31, 2020), unless otherwise extend by the City thereafter.

RECOMMENDATION:

The Insurance & Benefits Committee, as well as our office, recommends that the Council pass this Resolution.

c: Teresa Durm
Dennis R. Triggs

RESOLUTION NO. 1920-139

East Peoria, Illinois

_____ , 2020

RESOLUTION BY COMMISSIONER _____

**RESOLUTION REGARDING REVISIONS TO THE CITY'S
GROUP HEALTH INSURANCE PLAN**

WHEREAS, the City of East Peoria maintains a self-insured group health care plan ("Plan") for the benefit of its employees, with the entire Plan booklet most recently being re-issued and effective on January 1, 2015; and

WHEREAS, with the change in the provider of the utilization management services for the Plan, revisions to the Plan document are necessary to ensure the Plan properly references the correct entities that provide certain services for Plan participants; and

WHEREAS, the City's Insurance and Benefits Committee has determined that offering expanded preventative care benefits for mammograms and colonoscopies will benefit Plan participants, while ensuring that preventative medical care is available that will improve the long-term health of Plan participants, while helping to reduce costs on a long-term basis for both Plan participants and the Plan; and

WHEREAS, the City's Insurance and Benefits Committee, by a proper vote, has approved such Plan changes as provided below for implementation at the beginning of the new Plan year on May 1, 2020; and

WHEREAS, at the beginning of the impact of the COVID-19 pandemic crisis in Illinois, the Mayor approved an amendment to the Plan on an emergency basis that specifically addressed specific benefits for Plan participants potentially affected by COVID-19 and the related crisis and the stay-at-home Executive Order issued by the Governor, and also addressed qualification for the reinsurance coverage under the Plan (the "COVID-19 Plan Amendment"), and the Council now seeks to approve and ratify this COVID-19 Plan Amendment, which will be effective for the one-year period commencing on March 20, 2020; and

WHEREAS, the City's Insurance and Benefits Committee recommends that the City adopt these revisions to the Plan to be effective as provided herein;

NOW, THEREFORE, BE IT RESOLVED BY THE COUNCIL OF THE CITY OF EAST PEORIA, TAZEWELL COUNTY, ILLINOIS, THAT:

Section 1. The City adopts the change recommended by the Insurance and Benefits Committee to Section 7.1(h) of the Plan as follows to be effective May 1, 2020 (additions are indicated by underline; deletions by ~~strikeout~~):

7.1 Limitations

(h) Chemotherapy/Oncology Pharmaceutical Drugs

For certain aspects of care received by cancer patients, this provision describes a special medical management program for related benefits under the Plan. For any intravenous chemotherapy, including the chemotherapy prescription drug, **pre-certification shall be required by contacting Precedence Inc. at (800) 361-1492** ~~Biologics/Oncosentrics at (800) 983-1590.~~

(1) Oncology Pharmaceutical and Clinical Management Program

This Plan has entered into an arrangement with Precedence Inc. Biologics, a company specializing in oncology management, to assist a Covered Person or Covered Dependent and the Covered Person's or Covered Dependent's oncologist during the course of cancer treatment when administered in an inpatient setting or outpatient setting (e.g. in the physician's office or other covered outpatient setting). This program applies to the chemotherapy plan of treatment and other oncology pharmaceuticals to be used in connection with cancer treatment for a Covered Person or Covered Dependent.

In order to initiate these oncology management program services, the Covered Person's or Covered Dependent's oncologist should contact the Contract Administrator (Consociate) to verify Plan benefits. At that time, the oncologist will be asked to contact Precedence Inc. Biologics and provide the assigned Precedence Inc.'s Biologics' Oncology Nurse Specialist (ONS) with a copy of the treatment plan prescribed by the oncologist for the Covered Person or Covered Dependent. After the oncologist has contacted Precedence Inc. Biologics, an ONS will contact the Covered Person or Covered Dependent periodically to provide support, education, and answer any questions about the disease and prescribed treatment plan. The ONS will remain in contact with the Covered Person or Covered Dependent and the oncologist for the duration of the chemotherapy treatment plan. In addition, clinical oncology pharmacists will be available to the Covered Person or Covered Dependent and the oncologist on a 24-hour/7-day per

week basis by contacting (800) ~~361-1492~~ ~~983-1590~~. The Covered Person or Covered Dependent should call this number with any questions regarding the cancer drugs being used in the treatment program, related side effects, and other quality of life issues.

If the oncologist determines that oral anti-cancer drugs or supportive medications should be taken at home following inpatient or outpatient chemotherapy, the oncologist should contact Precedence Inc. Biologics and the prescribed drugs will be sent directly to the Covered Person's or Covered Dependent's home or other specified location in time to meet the medication schedule specified by the oncologist. A clinical oncology pharmacist will call the Covered Person or Covered Dependent to discuss the medications and answer any questions about the specific drugs being taken at home.

Unless the Covered Person's or Covered Dependent's oncologist has entered into an agreement with Precedence Inc. Biologics to accept other reimbursement rates for Expenses Incurred for the chemotherapy or oncology pharmaceutical drugs, the payment under this Plan for Expenses Incurred for all such pharmaceutical drugs used in the treatment of cancer will be limited to the rate of Average Sales Price plus ten percent (10%). Average Sales Price is updated quarterly by Medicare.

(2) Exclusion: Experimental and Investigational Drugs

In order to receive benefit payments under the Plan for Expenses Incurred for chemotherapy or oncology pharmaceutical drugs, the chemotherapy plan of treatment for the Covered Person or Covered Dependent must be received by Precedence Inc. Biologics and deemed not to be Experimental or Investigational as described herein. The Plan will not pay for or otherwise cover the cost of drugs considered Experimental or Investigational, except as specifically provided in Section 7.8.

In the context of pharmaceutical drugs used in the treatment of cancer, the use of a drug will not be considered Experimental or Investigational where (1) the use of the drug has been recognized as safe and effective for the treatment of the specific type of cancer in the National Comprehensive Cancer Network's Drugs and Precedence Inc. Biologics Compendium, Thomson Microdex DRUGDEX, Thomson Microdex DrugPoints or Clinical Pharmacology; or (2) the drug is provided in association with a Phase III or IV trial for cancer, as approved by the FDA or sanctioned by the National Cancer Institute "NCI"); or (3) the drug

is provided in association with a Phase II trial for cancer by an NCI-sponsored group and standard treatment has been or would be ineffective or does not exist or there is no clearly superior non-investigational alternative that can be delivered more cost efficiently as determined by the Contract Administrator.

Section 2. The City adopts the change recommended by the Insurance and Benefits Committee to Section 7.1(j) of the Plan as follows to be effective May 1, 2020 (additions are indicated by underline; deletions by ~~strikeout~~):

7.1 Limitations

(i) Dialysis Treatment: Cost Management Program

For dialysis treatment for a Covered Person or Covered Dependent, this provision describes a special cost management program for related benefits under the Plan. **For any dialysis treatment program, pre-certification shall be required by contacting Precedence Inc. at (800) 361-1492 ~~EthiCare Advisors at (877) 218-4955.~~**

The dialysis treatment cost management program is a special cost containment program designed for a Covered Person or Covered Dependent requiring dialysis treatments. The Plan has entered into an arrangement with Zelis Healthcare ~~EthiCare Advisors, Inc.~~, a specialized cost management company, to assist with managing dialysis costs, and this dialysis treatment cost management program is coordinated by Precedence Inc. ~~Precedence Inc. EthiCare Advisors~~ must be contacted by the Covered Person's or Covered Dependent's nephrologist or the dialysis treatment clinic providing services before the onset of the dialysis treatment program. Unless the nephrologist or dialysis treatment clinic has entered into an agreement with Zelis Healthcare ~~EthiCare Advisors~~, the payment under this Plan for any Expenses Incurred for all drugs and dialysis treatment will be strictly limited to the usual and customary reimbursement rate as defined by the Plan and all other Plan Limitations and Exclusions.

Section 3. The City adopts the change recommended by the Insurance and Benefits Committee to Section 7.2(b)(1) of the Plan as follows to be effective May 1, 2020 (additions are indicated by underline; deletions by ~~strikeout~~):

7.2 Non-Deductible Medical Benefits (100% Coverage at PPO)

(b)(1) Women's Preventative Care - Routine Mammogram

This Plan pays 100% of Reasonable and Customary Expenses Incurred for a routine mammogram ~~within the following limitations~~ as

provided herein. If the Covered Person or Covered Dependent is a female, ~~age 35 or over,~~ one baseline mammogram will be covered at any age and thereafter. ~~If the Covered Person or Covered Dependent is a female age 40 or over,~~ one routine mammogram for each calendar year will be covered as recommended by a Physician. If a second or additional mammogram is ordered within the same calendar year or within six months of the previous mammogram, this second or additional mammogram will be covered ~~as provided for medical care under the applicable Plan option~~ under the PPO Health Plan option as a Medical Benefit Requiring Coinsurance with no copayment under Section 7.4(c) and covered under the High Deductible Health Plan as a Non-Deductible Medical Benefit Requiring Coinsurance under Section 7.5(a).

Section 4. The City adopts the change recommended by the Insurance and Benefits Committee to Section 7.2(g) of the Plan as follows to be effective May 1, 2020 (additions are indicated by underline; deletions by ~~strikeout~~):

7.2 Non-Deductible Medical Benefits (100% Coverage at PPO)

(g) Colon and Rectal Exam

This Plan pays 100% of Reasonable and Customary Expenses Incurred for a routine colon and rectal examination for a Covered Person or Covered Dependent age 50 or over within the following limitations:

- (1) Annual fecal occult blood test or fecal immunochemical test;
- (2) Flexible sigmoidoscopy once every 5 years;
- (3) Double-contrast barium enema once every 5 years; ~~and~~
- (4) Colonoscopy once every 10 years; and
- (5) Colonoscopy once every 5 years if Covered Person or Covered Dependent has a family history of colorectal cancer or if recommended by a Physician; a colonoscopy conducted at a higher frequency than provided under this Section 7.2(g) will be covered under the PPO Health Plan option as a Medical Benefit Requiring Coinsurance with no copayment under Section 7.4(c) and covered under the High Deductible Health Plan as a Non-Deductible Medical Benefit Requiring Coinsurance under Section 7.5(a).

Section 5. Section 6. The “Summary of Benefits” section of the Plan shall be modified as provided in Exhibit A, attached hereto and incorporated by reference, and replacing the current version of the “Summary of Benefits” section of the Plan effective May 1, 2020.

Section 6. The City adopts and ratifies the COVID-19 Plan Amendment, as provided in Exhibit B, attached hereto and incorporated by reference, which shall be effective from March 20, 2020, through March 19, 2021.

Section 7. The City's Human Resources Director is directed to furnish or otherwise make available a copy of these changes or an updated version of the Plan document to all City employees and officials covered by the Plan, including any retirees, employees on disability, families of deceased employees, or former employees who are covered by the Plan.

APPROVED:

Mayor

ATTEST:

City Clerk

**EXHIBIT A: Effective May 1, 2020
SUMMARY OF BENEFITS**

Contract Administrator

Consociate
Mailing Address: 2828 N. Monroe Street, P.O. Box 678, Decatur, Illinois 62525
Walk-In Address: 425 N. Main Street, 4th Floor, East Peoria, Illinois 61611
Phone: (800) 798-2422
Website: www.consociate.com

Prescription Benefits Manager

MedTrak
7101 College Boulevard, Suite 1000
Overland Park, KS 66210
Phone: (800) 771-4648
Website: www.medtrakrx.com

Virtual Care Provider

Online:
www.unitypointvirtualcare.org
Smart Phone App:
"UnityPoint Health Virtual Care"

Medical Care: Wellness and Women's Preventative Care
(Same for all Health Plan Options)

Benefits paid at 100% at Preferred Provider (pages 48-52)

Wellness Benefits

Immunizations

PSA Testing..... once per year, age 50 or older

Colon & Rectal Exam..... see benefit description, age 50 or older

Physical once per year

Baby Well-Care (through 2nd birthday) unlimited visits

Women's Preventative Care

Mammograms..... once per year

Pap Smear..... once per year

Gynecological Exam once per year

Additional Preventative Care as set forth in Plan

Contraceptives..... generic, unless generic not available

Medical Care: LIMITATIONS (Same for all Health Plan Options)

PRE-CERTIFICATION PROCESS: Utilization Review (pages 44-45)

Penalty (preferred provider) up to \$500 **penalty**
(\$1,000 **penalty** for non-preferred provider) if not followed

MUST CALL Precedence Inc. (800) 361-1492 for prior authorization:
Inpatient Care (including partial hospitalization for behavioral health),
Outpatient Surgery (requiring anesthesia), Dialysis, Transplant evaluation,
Chemotherapy, Radiation and Oncology Pharmacology

Medical Care: LIMITATIONS (continued)

NON-PREFERRED PROVIDER INPATIENT \$500 **penalty**,
HOSPITALIZATION to be paid before benefits applied

Skilled Nursing Facility
Room and board rate semi-private room rate
Maximum days per confinement 120

Home Health Care 120 visits per calendar year

Annual Maximum Benefit (page 43) None
(No lifetime maximum limits on benefits)

Medical Care: PPO Health Plan

(Pages 52-70)

Deductible for Medical Care per calendar year
Individual \$0
Family \$0

Non-Preferred Provider
Individual \$3,750
Family \$7,500

Out-of-Pocket Maximum per calendar year
Preferred Provider
Individual \$3,500
Family \$7,000

Non-Preferred Provider
Individual \$7,500
Family \$15,000

NOTE: Medical Copays apply to meeting OOP Maximums; however, copays still apply after meeting OOP Maximum levels (coinsurance would increase to 100%). Prescription drug costs do not apply to OOP Maximums.

NOTE: Payment made in satisfaction of either the Preferred Provider or the Non-Preferred Provider out-of-pocket maximum is not credited toward the satisfaction of the other out-of-pocket maximum.

Physician Care: Primary Care

Non-surgical office visit (includes routine office visit; mental or nervous disorders or substance abuse care; and physical, occupational, and speech therapy)

Medical Care: PPO Health Plan (continued)

Preferred Provider 100% after \$40 copay
Non-Preferred Provider..... 50%

Physician Care: Specialty Care & Urgent Care

Non-surgical office visit with a specialist or at an urgent care facility
Preferred Provider 100% after \$60 copay
Non-Preferred Provider..... 50%

NOTE: Additional medical services obtained at Physician's Office may require additional copay or coinsurance.

Virtual Care Consultation (Preferred Provider)..... 100% after \$10 copay

Medical Services: Office Visit & Outpatient

Diagnostic tests, x-ray, pathology, etc.
Preferred Provider 80%
Non-Preferred Provider..... 50%

MRI, PET and CT Scan: Outpatient

Preferred Provider 80% after \$250 copay
(A maximum copay of \$500 per year per individual)
Non-Preferred Provider..... 50%

Outpatient Surgery

(\$500 or \$1,000 **penalty** for failure to follow pre-certification procedures for outpatient procedures not performed in physician's office that require anesthesia; see pages 44-45)
Preferred Provider 80% after \$500 copay
Non-Preferred Provider..... 50%

Hospital Care

Inpatient & Mental Health and Substance Abuse / Newborn Care
(\$500 or \$1,000 **penalty** for failure to follow pre-certification procedures; see pages 44-45)
Preferred Provider 80% after \$500 copay
Non-Preferred Provider..... 50%

Medical Emergency

Preferred Provider 100% after \$200 copay
Non-Preferred Provider..... 100% after \$200 copay
Waived if admitted of Inpatient Care
Hospital copay and coinsurance apply for any post-ER hospital care

Ambulance Transport 80% after \$100 copay

Medical Care: PPO Health Plan (continued)

Prescriptions (outpatient) (pages 68-69)

Single Prescription or Refill (34 day maximum supply)

Generic.....\$5 copay
Brand (no generic available..... \$30 copay + 25%
up to total maximum cost of \$75 per prescription
Brand (generic available) ... \$75 copay+100% difference brand-generic

MedTrak Performance 90 (90-day prescription)

Generic..... \$12.50 copay
Brand (no generic available..... \$75 copay + 25%
up to total maximum cost of \$200 per prescription
Brand (generic available) . . \$200 copay+100% difference brand-generic

Specialty Prescriptions (does not include brand with generic available)

Single Prescription/Refill: \$500 or more Regular copay + 25%

Insulin

No copay (\$0) when using provider on Preferred Insulin List
Brand copay amount (generic available) if not using provider on Preferred Insulin List

Medical Care: High Deductible Health Plan

(Pages 70-86)

Under the High Deductible Health Plan, the participant pays 100% of all costs (except for Wellness Benefits and Women’s Preventative Care at PPO provider) until meeting deductibles. Thereafter, the Plan pays 90% of costs for medical care at PPO provider (50% at Non-PPO provider), including prescription drugs.

Deductible for Medical Care per calendar year

Individual \$2,500
Family..... \$5,000

Qualifying expenses will apply toward deductibles up to amounts listed above; however, after these amounts are met, qualifying expenses at a Non-Preferred Provider shall be further subject to the deductibles listed below.

Non-Preferred Provider

Individual \$5,000
Family..... \$10,000

Medical Care: High Deductible Health Plan (continued)

Out-of-Pocket Maximum per calendar year

Preferred Provider	
Individual	\$2,500
Family	\$5,000
Non-Preferred Provider	
Individual	\$5,000
Family	\$15,000

Physician Care & Virtual Care Consultation

Non-surgical office visit (includes routine office visit; mental or nervous disorders or substance abuse care; chiropractic care; and physical, occupational, and speech therapy)

Preferred Provider	90%
Non-Preferred Provider.....	50%

Outpatient Surgery

(\$500 or \$1,000 **penalty** for failure to follow pre-certification procedures for outpatient procedures not performed in physician's office that require anesthesia; see pages 44-45)

Preferred Provider	90%
Non-Preferred Provider.....	50%

Hospital Care

Inpatient & Mental Health and Substance Abuse

(\$500 or \$1,000 **penalty** for failure to follow pre-certification procedures; see pages 44-45)

Preferred Provider	90%
Non-Preferred Provider.....	50% after payment of \$500 penalty for non-emergency care

Outpatient

Preferred Provider	90%
Non-Preferred Provider.....	50%

Medical Emergency

90%

Ambulance Transport

90%

Medical Care: High Deductible Health Plan (continued)

Prescriptions (outpatient; after deductibles are met) (pages 83-85)

Single Prescription or Refill (34 day maximum supply)
Generic and Brand (no generic available) 90%

MedTrak Performance 90 (90-day prescription)
Generic and Brand (no generic available) 90%

Specialty Prescriptions (does not include brand with generic available)
Generics and Brand:
Single Prescription/Refill 90%

Brand (generic available): 10% copay plus 100% difference brand-generic

Insulin (outpatient)

No copay (\$0) when using provider on Preferred Insulin List (before and after deductibles are met)

Brand copay amount (generic available) if not using provider on Preferred Insulin List (after deductibles are met)

Dental Care (pages 90-94)
(Same for all Health Plan Options)

Deductible per calendar year

Individual\$100

Family\$300

Preventative Dental Services, including a dental exam and cleaning twice per calendar year, periodic bitewing X-rays, and dental sealants up to age 16 100%

Other Basic Dental Services 80%

Major Dental Services, including dentures, and space maintainers 50%

Maximum Dental Care Benefit per calendar year \$1,500 per person

Orthodontics..... 50% up to Lifetime Maximum
Lifetime Maximum.....\$2,000 per person

Vision Care (pages 95-96)
(Same for all Health Plan Options)

Benefit Period	12 months
Eye Exam.....	100% after \$25 copay
Lenses/Frames and/or Contact Lenses	
Maximum per Benefit Period	\$250 per person

**EXHIBIT B: Effective March 20, 2020
COVID-19 PLAN AMENDMENT**

**Amendment to
Plan Document and Summary Plan Description for
City of East Peoria Group Health Care Plan**

This Amendment to the City of East Peoria Group Health Care Plan (“Plan”) is made effective March 20, 2020, as set forth below.

WHEREAS, applicable provision of the Plan grant the City the right to amend the Plan; and,

WHEREAS, the City desires to make such amendment to address the 2019 Novel Coronavirus (COVID-19) outbreak crisis;

NOW, THEREFORE, the Plan is hereby amended as follows to provide enhanced health benefits associated the 2019 Novel Coronavirus (COVID-19), with such amendment to be effective on and after the date listed herein and terminating on the anniversary of the effective date noted below.

Covered expenses associated with COVID-19 include the following:

1. **COVID-19 Testing** (Medically Necessary clinical diagnostic laboratory tests when a doctor or other Provider orders them; Providers must follow the Centers for Disease Control (CDC) guidelines regarding screening/testing for charges to be Covered Expenses) will be covered at 100%. No deductible, copayment or coinsurance applies.
2. **Tele-health and Other Communication-Based Technology Services** will be covered at 100%. No deductible, copayment or coinsurance applies.
3. **Requests for Early Prescription Refills.** To ensure Covered Persons have at least a one month supply of prescription medicines on-hand, the Plan and its Prescription Drug Plan Administrator will, on a case-by-case, basis, consider each request for an early prescription refill and make decisions based on the circumstances of the patient.
4. **Inpatient Hospital Quarantines.** There may be times when Covered Persons with the virus need to be quarantined in a Hospital private room to avoid infecting other individuals. These patients may not meet the need for acute inpatient care any longer but may remain in the Hospital for public health reasons. Such charges will not be denied solely because otherwise-applicable Medically Necessary requirements would not indicate a need for a private room.

5. **Non-Emergency Ambulance Transportation.** The Plan will cover limited, Medically Necessary, non-emergency ambulance transportation relating to COVID-19 Diagnosis or treatment.
6. **Continuation of Coverage:**
 - a. Employees considered Actively at Work the day prior to any temporary closure or temporary reduction of workforce due to COVID-19 will be considered Actively at Work during the temporary closure or temporary reduction of workforce.
 - b. If due to COVID-19 Social Distancing guidelines, employees on non-medical leave of absence or unable to work remotely will have continued coverage.

The above benefits are specific to COVID-19. Covered Persons who have been diagnosed with COVID-19 will continue to receive all other benefits covered by the Plan, in accordance with the Plan's guidelines.

Should there be any conflict between this Amendment and the Plan document, the provisions of this Amendment shall govern.

All other provisions of the Plan document remain as stated. The above is effective on and after the date stated herein.