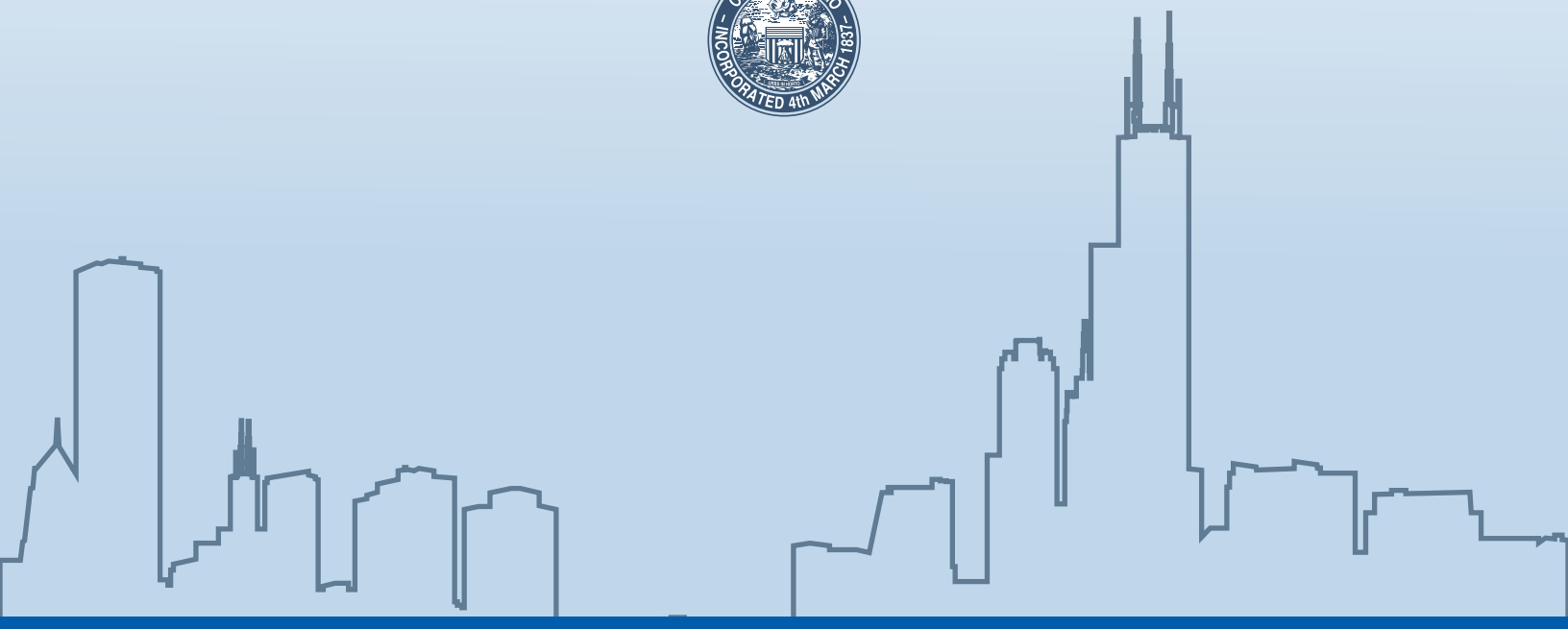
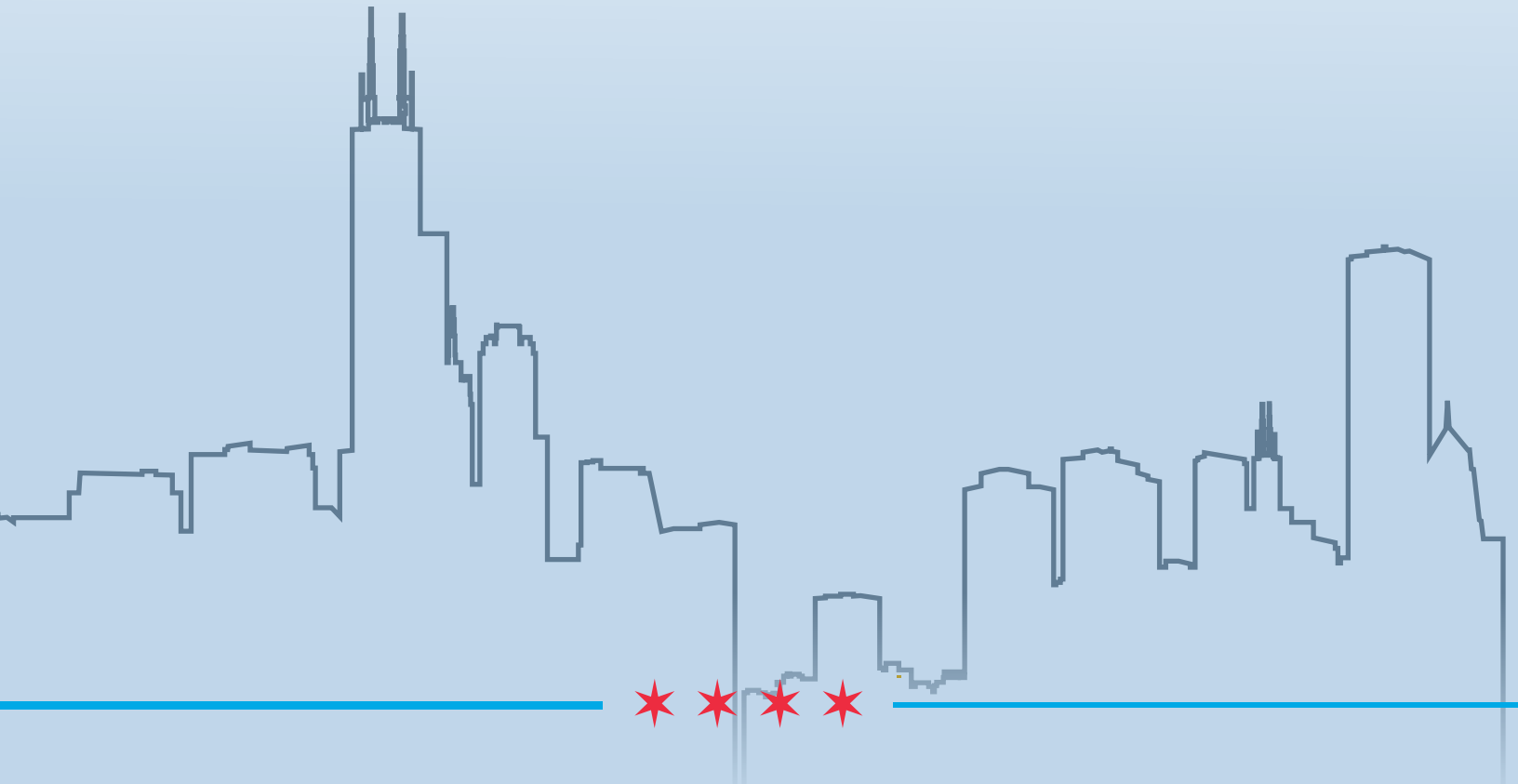
CHICAGO
BENEFITS OFFICE

HEALTHCARE AND OTHER BENEFITS
OPEN ENROLLMENT GUIDE
Seasonal Employees
2022



For non-represented employees, and for employees covered under the City's collective bargaining agreements with: The American Federation of State, County and Municipal Employees Council 31, Coalition of Unionized Public Employees (Chicago Building Trades Coalition); Illinois Nurses Association; Public Safety Employees Unit II; Police Captains Association, Police Lieutenants Association, and Police Sergeants represented by the Policemen's Benevolent & Protective Association of Illinois (PB&PA); Supervising Police Communications Operators represented by Teamsters Local 700; Aviation Security Sergeants represented by the Illinois Council of Police; Public Health Nurse III's and IV's represented by Teamsters Local 743, and Uniformed Firefighters and Paramedics represented by the Chicago Fire Fighters Union Local No. 2 and the Shift Supervisors of Security Communications Center represented by Teamsters Local 700.



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Plan C effective 1/1/2022. This is a summary of benefits offered to City Employees (excluding Sworn Police Officers below the rank of Sergeant and Seasonal Employees). The Plan Document and subsequent updates always supersede this summary.

WELCOME

As a City of Chicago (CoC) employee, you have access to a wide variety of benefits. Your benefits are designed to help keep you and your family healthy and financially secure with coverage options that feature choice, flexibility, and tax-savings.

Annually, the Chicago Benefits Office coordinates an Open Enrollment period to allow you and your family to review your coverage and make changes or add a new benefit, as desired. This year, Open Enrollment is from **October 13, 2021 through October 27, 2021,** with **changes effective January 1, 2022.**

This Healthcare and Other Benefits Open Enrollment Guide is intended to provide an overview of the benefits available and the deadlines associated with the annual Open Enrollment process. Included in this Guide are summary explanations of benefits as well as contact information for each provider. Be sure to pay close attention to applicable co-payments and deductibles, preauthorization requirements and some services that may be limited or not covered.

Every effort has been made to ensure that the information in this Guide is accurate; however, the provisions of the City Plan document and subsequent updates always supersede this summary. Copies of the Plan document is available at **www.chicago.gov/benefits**.

It is your responsibility, before you enroll or change your benefits, to make sure you understand the Plan and ask any questions by contacting the **Benefits Service Center at 1-877-299-5111.**

Sincerely,

Chicago Benefits Office

Chicago Labor Management Cooperation Committee (LMCC)

Dear Employees:

The Labor Management Cooperation Committee (LMCC) was created in 2007 as a 501(c)(3) entity that is governed by a Trust Agreement among the City of Chicago and labor representatives. Since the Trust's beginning, City officials and union leaders have been working to reduce costs and to keep your employee benefits package working for you.

Over the years, the LMCC has worked closely with the City of Chicago to implement cost saving measures in the City's health plans, including mail order prescription for maintenance medication, counseling for members with certain chronic conditions, tiered networks in the PPO to obtain the best discounts, and many other initiatives.

During the pandemic, the LMCC continued to meet remotely. This year the LMCC approved an increase in the number of outpatient mental health, substance abuse and physical therapy sessions for which no prior approval is required from seven visits to ten visits in the Blue Choice Options PPO Plan. Telligen reviews must occur before the 11th visit. For additional information on this program, and on finding health providers, wellness information and plan details, please visit the Blue Cross Blue Shields of Illinois website at **www.bcbsil.com/cityofchicago** or the Chicago Benefits Office website at **www.cityofchicago.org/benefits**

Some members have requested information on their COVID vaccination records and on COVID testing coverage offered by the health plans. Please visit the State of Illinois ICare website for vaccination information at **https://dph.illinois.gov/topics-services/prevention-wellness/immunization/icare**. At this time, there are no frequency limits and this applies to all COVID-19 tests including rapid tests and home tests.

The LMCC thanks you for all your work and flexibility during these difficult times. We look forward to working with you to continue to improve your health in 2022.

Sincerely,

The City of Chicago Labor Management Cooperation Committee

ANNUAL OPEN ENROLLMENT

Begins October 13, 2021 and ends on October 27, 2021

Open Enrollment Changes are effective January 1, 2022

WHAT IS OPEN ENROLLMENT?

During this period, the City allows for its employees to elect, change or add benefits.

WHAT CAN I DO DURING OPEN ENROLLMENT?

- Enroll in or cancel your medical, vision, or dental insurance
- Switch medical or dental plans (if eligible)
- Add or remove dependents to your plan (for example a spouse, civil union or same sex domestic partner, or children)
- Sign up for a healthcare and/or dependent care Flexible Spending Account (FSA)
- Buy optional life insurance or voluntary long term disability insurance

If you do not make changes, your 2021 medical, dental, vision benefits will continue (excluding healthcare and dependent care FSA). **You must sign up and/or re-enroll for healthcare and dependent care FSA to participate in 2022.**

HOW DO I MAKE CHANGES?

You are strongly encouraged to go online at **www.cityofchicagobenefits.org** to make changes. The deadline to make changes is October 27, 2021, by 11:59 p.m. You may also call the **Benefits Service Center at 1-877-299-5111**.

During Open Enrollment, the Benefits Service Center hotline will be available

Monday through Friday from 8:00 a.m. until 7:00 p.m.

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WHAT IS NEW IN 2022

In the Blue Choice Options PPO Plan, a change was implemented to increase the number of outpatient mental health, substance abuse and physical therapy sessions for which no prior approval is required, from seven visits to ten visits. Telligen reviews must occur before your eleventh visit.

- You (or your provider) must call and obtain pre-certification after a combined total of 10 sessions from one or more providers.
- Call each year if care is on-going.
- If services are not pre-certified, the services are not covered by the PPO plan.

REMINDERS

You can submit eligibility documents for your dependents **online** at **www.cityofchicagobenefits.org**. You do not need to submit the documents in person.

If you have multiple pages to submit, you must scan all pages into one document before uploading.

(Only one document can be uploaded)

CHECK YOUR BENEFITS COVERAGE SHEET

Your 2021 personalized Benefits Coverage Sheet is included with this Guide. The medical, dental and vision enrollment listed on your Benefits Coverage Sheet will remain the same for 2022 unless you make changes during the open enrollment period which runs October 13, 2021 through October 27, 2021. You must enroll or re-enroll to participate in healthcare and dependent care FSA in 2022.

Dependent children who reach the age of 26 (30 for unmarried military) are automatically terminated from the City's health plan on the last day of the month of his/her birthday. Special rules apply to disabled dependents. For additional information regarding disabled dependents contact the Benefits Service Center at 1-877-299-5111.

Check the personalized Benefits Coverage Sheet to make sure the information is correct for you and your dependents. Call the Benefits Service Center to update any of this information for dependents:

- **Name and birthdate of a dependent.**
- **Social Security number of the dependent if marked as "N". Federal law requires us to ask for the Social Security number for everyone enrolled in the City's health plans.**

IF YOUR HOME ADDRESS CHANGES - Contact your Department's Human Resources Representative to update your address on file with the City. The Chicago Benefits Service Center cannot change your home address on record.

ENROLLMENT CHANGES DURING THE YEAR - Benefit enrollment changes are allowed throughout the year only if you have a qualifying life event such as marriage, divorce, birth or adoption of a child or loss of coverage through your spouse, civil union or domestic partner. **Call the Benefits Service Center within 30 days of the qualifying life event date**. If you try to make these changes as an open enrollment change, the coverage will not go into effect until January 1, 2022. **You must provide documents to prove the qualifying life event within 60 days of the event**. For information about qualifying life events visit www.cityofchicagobenefits.org.

Below are some common events:

LEGAL MARITAL STATUS Marriage, establishment of civil union, dissolving civil union, divorce, death	**DEPENDENTS** Birth, adoption, legal guardian for a child
COURT ORDER FOR DEPENDENT Coverage for the employee's dependent resulting from a court order (QMCSO, a "Qualified Medical Child Support Order")	**GAIN/LOSS OF COVERAGE** Your spouse/civil union partner/same sex domestic partner/ dependents loses coverage

Please note: Qualifying life events are effective on the event date but open enrollment changes are effective January 1, 2022. When you call the Benefits Service Center to report a qualifying life event change during the open enrollment period, be sure to explain that you are calling about a qualifying life change event and ask for benefits to be effective on the event date.

THE ONLINE BENEFITS WEBSITE
www.cityofchicagobenefits.org

You are strongly encouraged to use the online Benefits website, www.cityofchicagobenefits.org. You may also call the Benefits Service Center to make changes at 1-877-299-5111.

Instructions on how to access the online Benefits website are provided below.

Step 1: To enroll **online**, go to: **www.cityofchicagobenefits.org** to register, create your username, password, and establish security questions. If you are having difficulty registering, contact the Benefits Service Center at 1-877-299-5111.

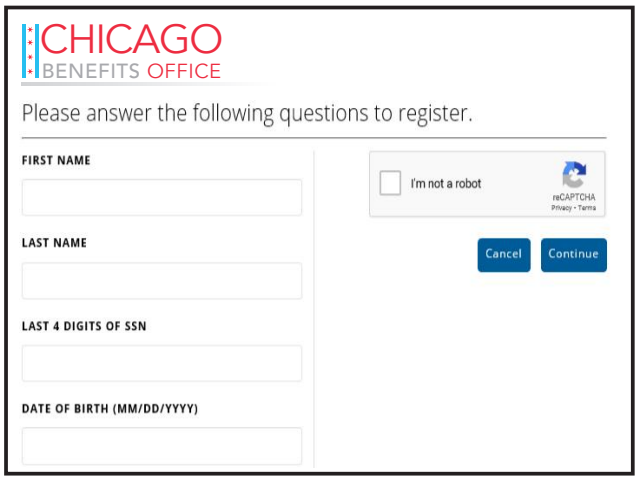
Step 2: **First-time users:** If you haven't used this website within the last year, you must register. Click register at the bottom.

Returning Users: Please follow the instructions under, "What's my initial password?"

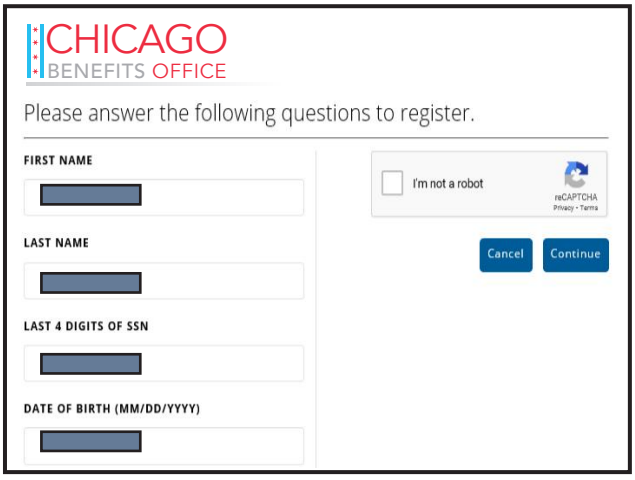
First time users / Returning Users

Step 3: Provide first name, last name, last 4 digits of SSN, and date of birth. You will verify "I am not a robot" by reviewing the photos and completing the process.

Self-Registration

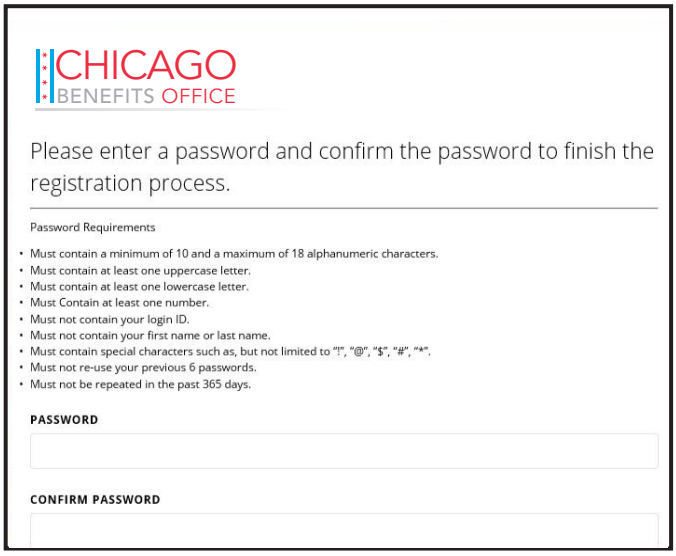


Self-Registration, Step 2



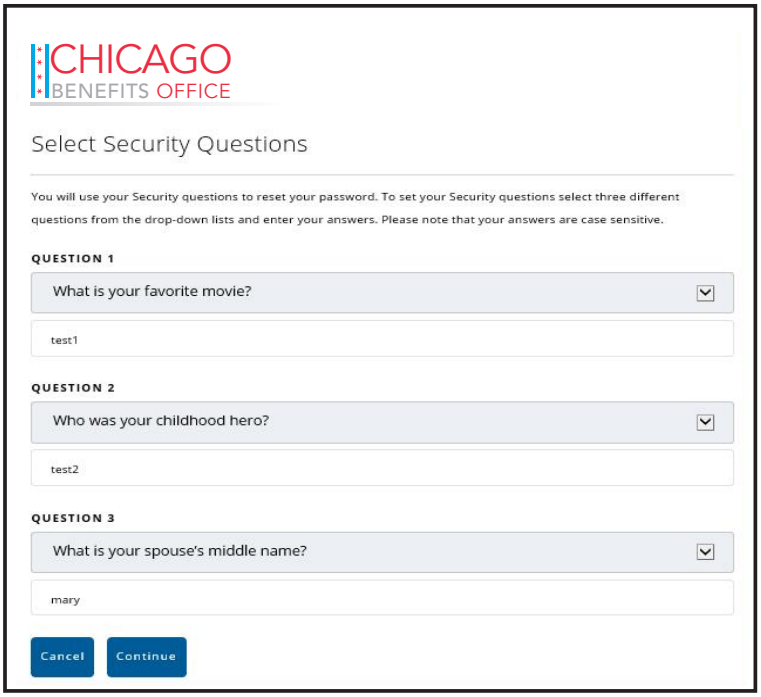
Step 4: Create and confirm a password.

Follow the instructions below.



You have successfully registered.

Step 5: Establish the Security Questions.



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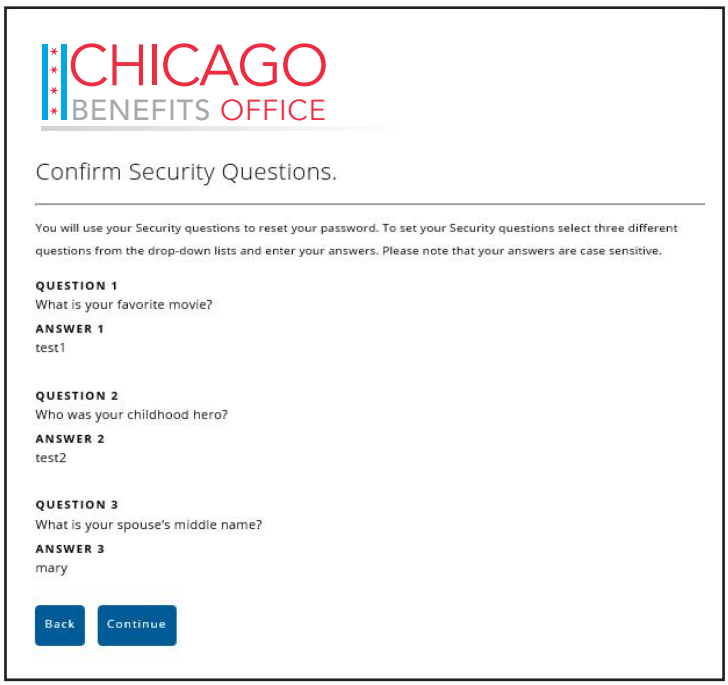
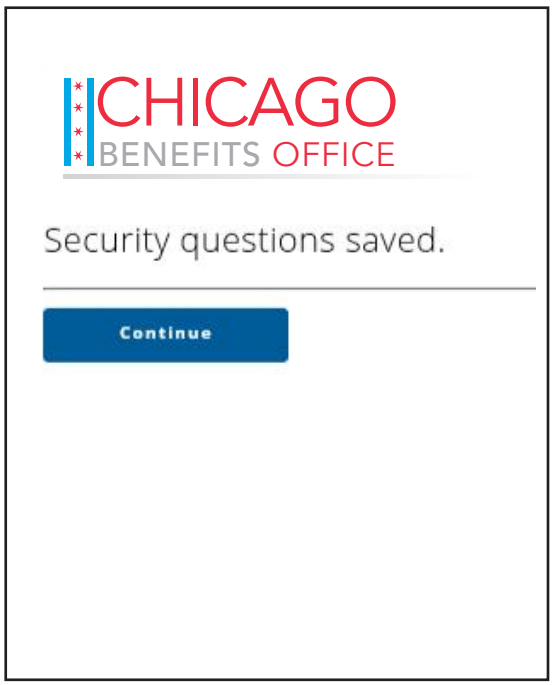
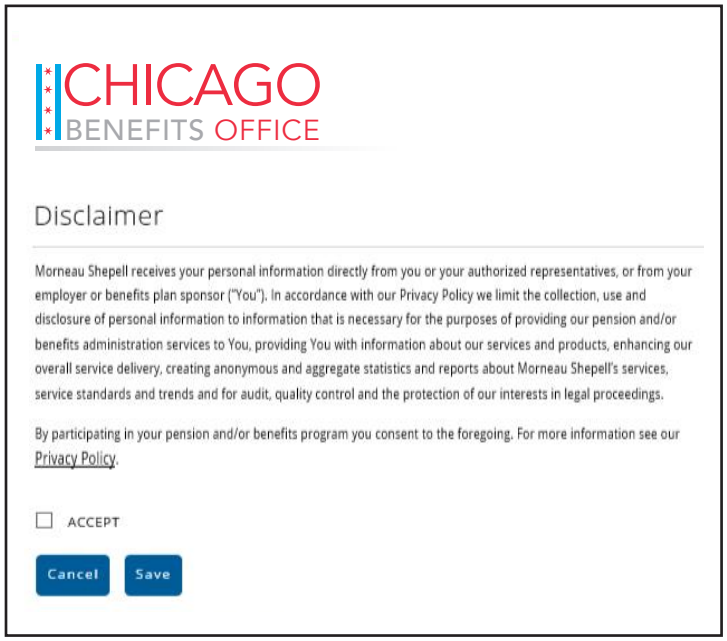
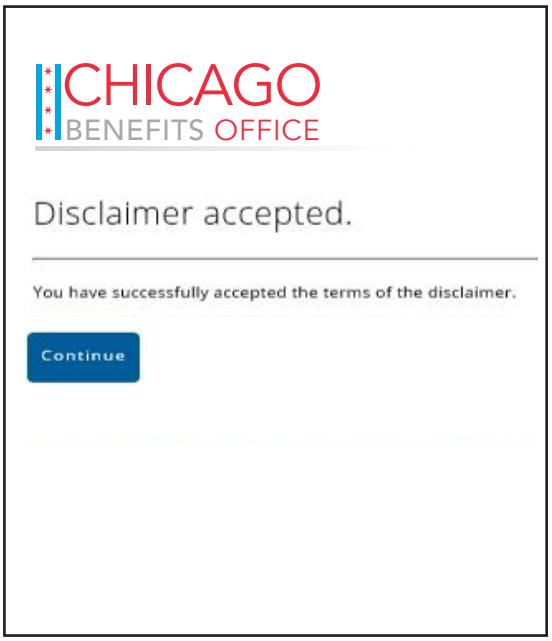
Step 6: Confirm your security questions and answers.





Step 7: Read the Disclaimer information and accept. If the Disclaimer is not accepted, you will not be able to move further with **online** enrollment.





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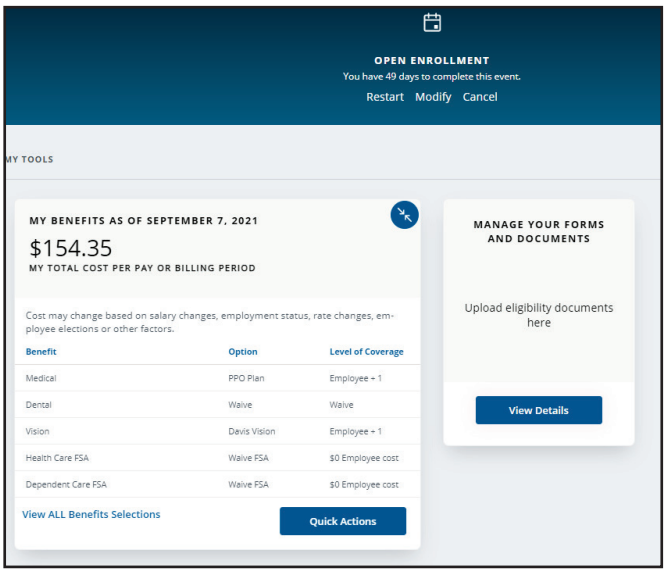
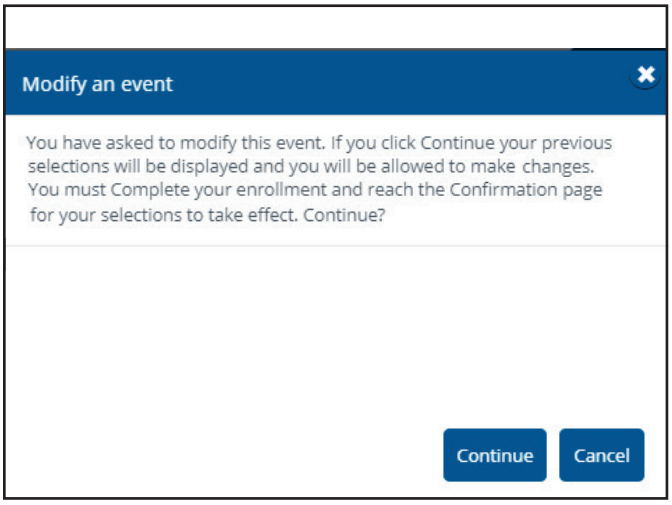
Welcome - You have made it to the Open Enrollment screen.

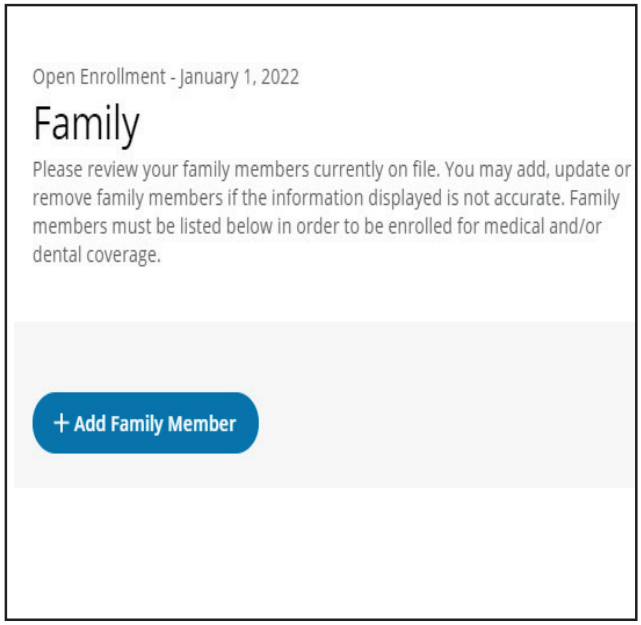


Click the "Modify" link to enter your event.

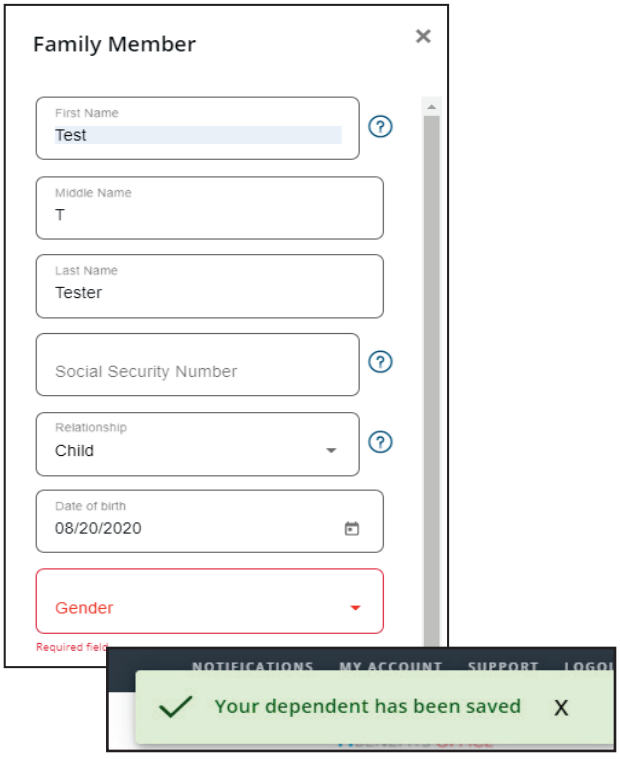


Step 8: Verify/Add Dependents

Click "Add Family Member"



Add dependent (provide name, social security, relationship, date of birth and gender).



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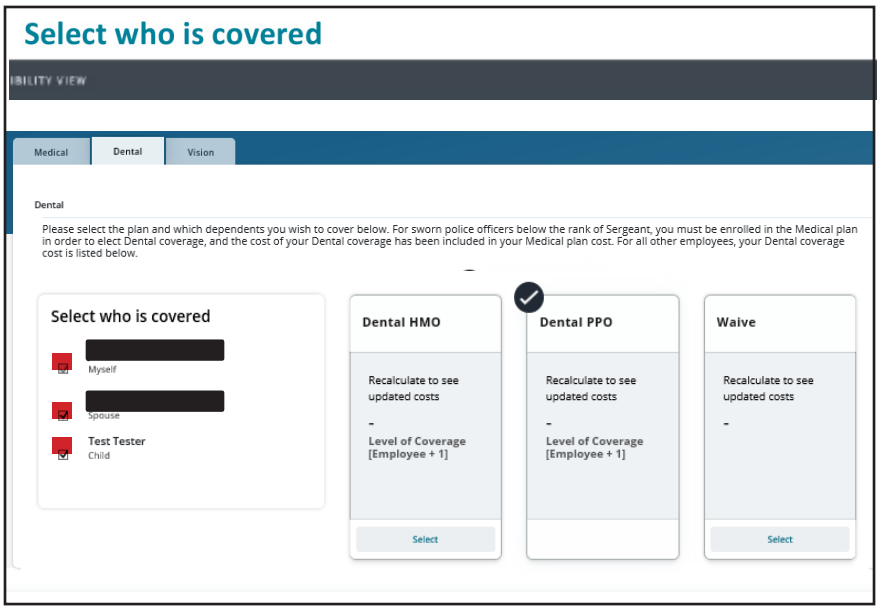
Step 9: Verify who is covered. Be sure to look at the separate tabs for each plan (medical, dental, vision). Remember to check the box for each dependent being added to each plan.

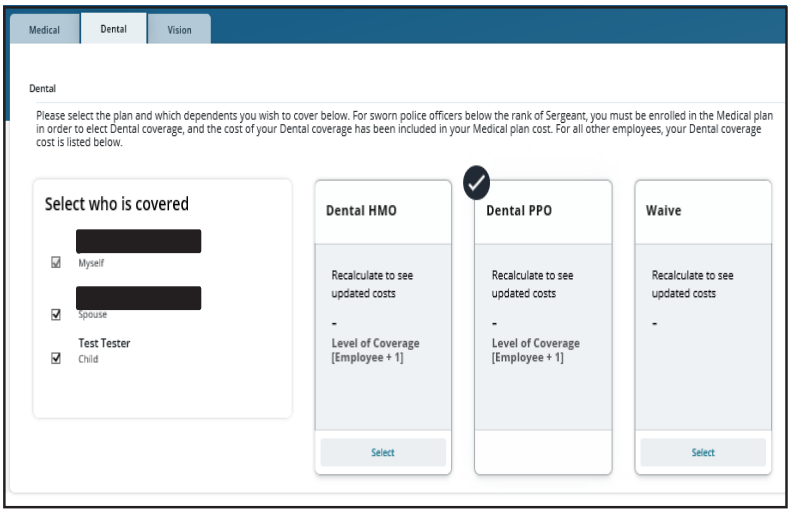


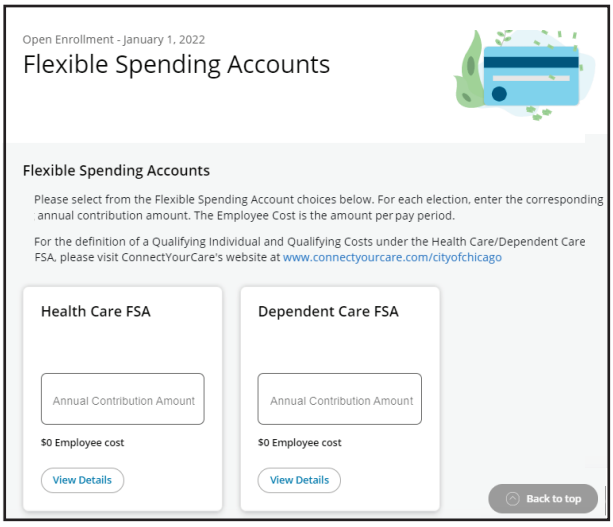
Step 10: Enrollment. When adding a dependent, you **MUST** add the dependent to **EACH PLAN** otherwise the dependent won't be covered in that plan. If you switch plans (example HMO to PPO) you have added a new plan and you **MUST** add dependents to cover them; this means if you fail to add your dependents to the new plan they won't be covered.

Each plan has it's own tab. Select eligible benefits to enroll under each tab:

- Medical – choose eligible plan: Blue Advantage HMO, PPO, Waive
- Dental – Dental HMO, PPO, Waive
- Vision – Davis Vision

Enroll or re-enroll in the healthcare and/or dependent care Flexible Spending Account (FSA) for 2022





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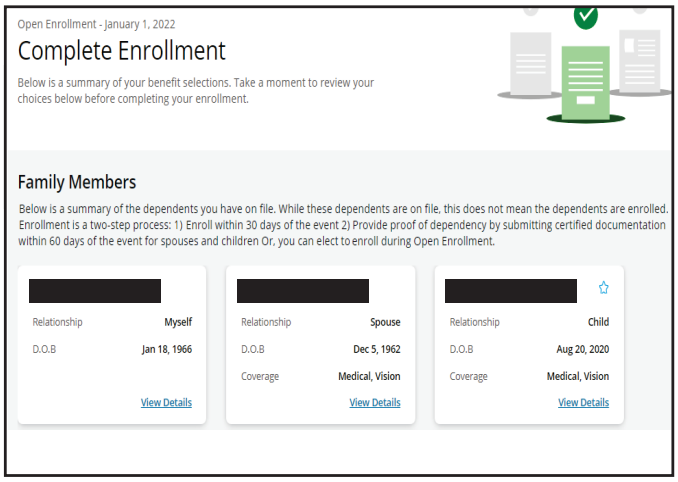
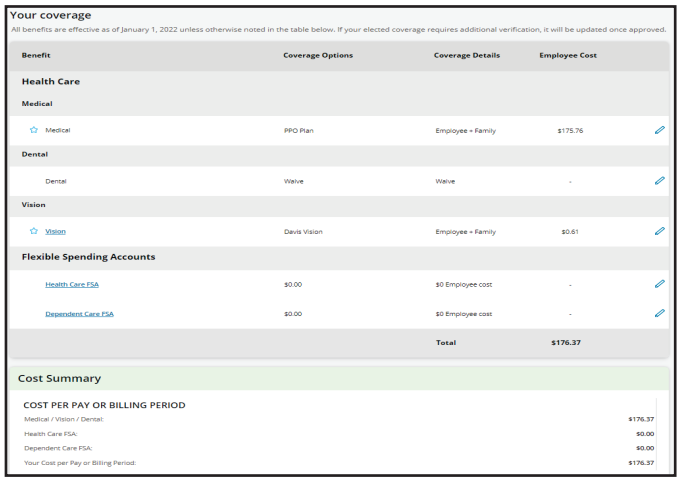
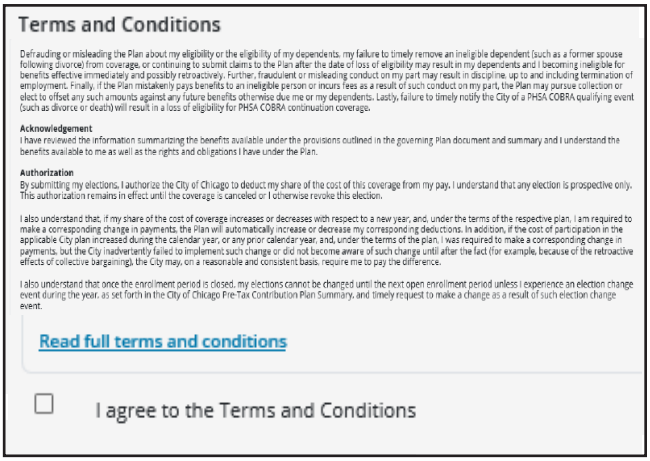
Step 10 continued: Complete Enrollment



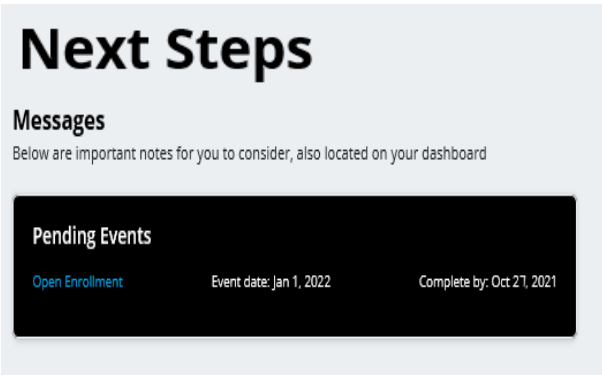


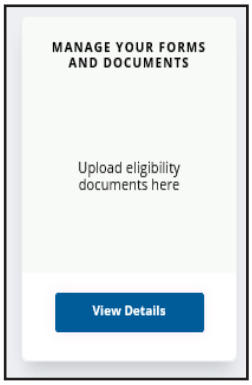
Read Terms. Click check box, acknowledging changes.

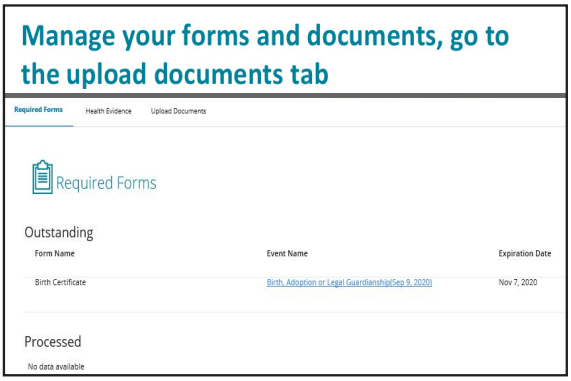


Confirmation – Enrollment Complete

If you are adding new dependents, your next step is to submit eligibility documentation (marriage or birth certificate, adoption or legal guardianship paperwork).







ADDING A DEPENDENT DURING OPEN ENROLLMENT?

STEP 1: – Enroll your dependents. Enroll your spouse, civil union partner, same sex domestic partner, and children during the open enrollment period **online** or by phone.

STEP 2: – For coverage to begin January 1, 2022 provide original eligibility documents to prove they are your legal dependents.

Your dependents will not have medical, vision or dental coverage effective January 1, 2022 if you fail to SUBMIT THE REQUIRED DOCUMENTATION BY THE DEADLINE BELOW.

DEADLINE: If you submit your dependent's eligibility documents by close of business **Wednesday, December 1, 2021** coverage will be active on January 1, 2022. For example, if your dependents seek medical care on January 1, 2022, your healthcare service provider will be able to verify coverage online. Please submit your documents **online** at **www.cityofchicagobenefits.org**. You may also submit your documents in person to the Chicago Benefits Office by this deadline to properly reflect coverage by the January 1st effective date. ***We encourage you to submit your documents right away to avoid the last minute rush.***

GRACE PERIOD. If you fail to submit your dependent's eligibility documents by **Wednesday, December 1, 2021**, you may submit documents through Thursday, December 30, 2021. **If you submit your dependents' documents from December 2, 2021 through December 30, 2021, your dependents may not have coverage on January 1, 2022.**

If you fail to submit your dependent's eligibility documentation by the end of the grace period on December 30, 2021, you will be required to wait until the next open enrollment period to enroll your dependents for coverage effective January 1, 2023.

IMPORTANT NOTICE: If an employee or dependent gives false information, or if the dependent is not a legal dependent of the employee, the City will take action to collect any money paid to cover healthcare expenses related to the fraud and/or report the fraud to the appropriate authority.

DO NOT WAIT UNTIL THE LAST MINUTE TO SUBMIT YOUR DEPENDENT'S ELIGIBILITY DOCUMENTATION

REQUIRED DOCUMENTS FOR DEPENDENTS: *A Summary*

Benefit Participant Being Added	Document(s) Needed
Spouse	An original certified marriage certificate and spouse's social security card.
Dependent (0-25yrs.)	An original certified birth certificate (with parental information) and child's social security card.
Unmarried military dependent children (Age 26-30), Illinois resident	An original certified birth certificate, social security card and honorable military discharge paperwork (DDForm214).
Adopted children	If the child is your adopted child and the birth certificate has not yet been amended to name you and other adoptive parent as the child's parents, then the letter issued by the governmental agency placing the child in your home will suffice for documentation, until such reasonable time as the amended birth certificate and the social security card can be issued.
Legal Guardianship of dependents- (Court appointed)	Certified guardianship documents from the Clerk of Circuit Court placing the child in the home (date of placement) and social security card.
Civil union partner	An original certified civil union certificate and partner's social security card.
Same Sex Domestic Partner	Certificate of Domestic Partnership issued by City Department of Human Resources before August 1, 2017 or an out of state agreement that is recognized as a civil union and the partner's social security card.

Employees should upload certified eligibility documents online at www.cityofchicagobenefits.org under Manage My Forms and Documents.

If you prefer to drop off certified eligibility documents in person please visit:

Chicago Benefits Office
333 South State Street
Suite 400
Chicago 60604-3978

Office hours are Monday through Friday 8:30 a.m. – 4:30 p.m.

If your documents are uploaded, the Chicago Benefits Office reserves the right to request original certified eligibility documents.

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WHAT YOU PAY FOR HEALTHCARE COVERAGE
MEDICAL PLANS (HMO and PPO)

(Contributions taken as payroll deductions: 24 pay periods each year)

Applies to All Seasonal Employees

ANNUAL SALARY	SINGLE	EMPLOYEE+1	FAMILY
Up to $30,000 (flat rate)	$15.71	$23.88	$27.65
$30,001 to $129,999	2.7921% of payroll ÷ 24	3.4854% of payroll ÷ 24	3.9765% of payroll ÷ 24
$130,000 and Above (flat rate)	$151.24	$188.79	$215.39

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WHAT YOU PAY FOR HEALTHCARE COVERAGE
DENTAL AND VISION

(Contributions taken as payroll deductions; 24 pay periods each year)

Applies to everyone (except Crossing Guards)

DENTAL & VISION INSURANCE

PLAN	SINGLE	EMPLOYEE+1	FAMILY
DENTAL HMO	$0.20	$1.08	$2.78
DENTAL PPO	$0.51	$1.02	$2.05
VISION	$0.15	$0.30	$0.61

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MEDICAL PLANS AT A GLANCE

You can select a PPO or HMO from **Blue Cross Blue Shield of Illinois.**

HMO and PPO Summary of Medical Plan Differences

PPO	HMO
There are deductibles, coinsurance and copays	No deductibles or coinsurance. There are co-pays.
Covers in-network and out-of-network doctors. Offers financial savings depending on the tiers (See page 17)	Doctors must be selected from pre-approved list of doctors.
See a specialist without a referral. Pre-certification, however, is required for certain services such as MRIs, CT scans (for more information- see page 18).	Requires referral from your primary care doctor to see a specialist. Your primary care physician and the staff will manage and coordinate your care.

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BLUE CHOICE OPTIONS MEDICAL PPO-PLAN A

Administered by Blue Cross Blue Shield of Illinois

		Blue Choice OPT Tier 1	**Blue Choice OPT** Tier 2	**Out-of-Network** Tier 3
Annual Deductible	Individual Family	**$300** **$900**	**$450** **$1,350**	**$1,500** **$4,500**
Out-of-Pocket Limit	Individual Family	**$1,000** **$2,000**	**$1,700** **$3,400**	**$4,500** **$9,000**
PREVENTIVE CARE		**YOU PAY**		
Routine checkups & routine lab work for adults & children; well-baby care; well- women visits; mammograms; PSA; colonoscopies, hearing screenings		**$0 copay** No deductible	**$0 copay** No deductible	No coverage out-of-net-work for preventive care
OFFICE VISITS				
Primary Care Physician, lab work, x-rays, allergy shots, Mental health and substance abuse counseling		**$20 copay** does not apply to deductible	**$25 copay** does not apply to deductible	**40% PPO** allowed rate after out-of-network de-ductible plus balance billed by provider
Specialist Physician And Chiropractic Care (20 visits)		**$30 copay** does not apply to deductible	**$35 copay** does not apply to deductible	
Annual deductible must be paid before Plan covers these services:		**YOU PAY** **After Tier 1 deductible**	**YOU PAY** **After Tier 2 deductible**	**YOU PAY** **After Tier 3 deductible**
OUTPATIENT SERVICES*				
Outpatient surgery MRI, PET & CT scan*		**10% then $100 copay** if not performed at a free standing facility	**25% then $100 copay** if not performed at a free standing facility	**40%** PPO allowed rate plus balance
HOSPITAL SERVICES*				
Hospital stay* including inpatient surgery		**10%**	**25%**	**40%** PPO allowed rate plus balance
EMERGENCY ROOM CARE				
Emergency Room		**$200 co-pay waived if admitted to hospital**		
Emergency Room Treatment		**10%**		
Ambulance emergency care		**10% of PPO allowed rate – additional cost**		
MENTAL HEALTH & SUBSTANCE ABUSE*				
Inpatient hospitalization* **Outpatient therapy***		**10%**	**25%**	**40%** PPO allowed rate plus balance
ALTERNATIVES TO HOSPITAL CARE*				
Skilled nursing facility* **Home health care*, Hospice care***		**10%**	**25%**	**40%** PPO allowed rate plus balance
MATERNITY SERVICES				
Maternity management program		**No charge plus $100 cash incentive**		
Pre and post natal doctor visits		**$20 copay** (first visit)	**$25 copay** (first visit)	**40%** PPO allowed rate plus balance
Delivery and hospital stay*		**10%**	**25%**	
OUTPATIENT REHAB				
Physical therapy*		**10%**	**25%**	**40%** PPO allowed rate
OTHER SERVICES				
Occupational and speech therapy* (Limited to 60 visits annually)		**$20 copay**	**$20 copay**	**40%** PPO allowed rate plus balance
DME*: Oral Surgery; Ambulance transport between hospitals*		**10%**	**25%**	

*Care must be pre-certified by calling Telligen at 1-800-373-3727. See the next page.

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CERTAIN PPO SERVICES NEED TO BE PRE-CERTIFIED

Administered by Telligen

Telligen, the PPO medical advisor, needs to pre-certify the services listed below. There is a $1,000 penalty if Telligen is not contacted in a timely fashion in the event of a hospitalization. This $1,000 penalty does not go towards the deductible or get counted in the out-of-pocket maximum. Telligen's phone number is 1-800-373-3727. This number is also on the back of the PPO ID card.

When To Call Telligen at 1-800-373-3727

HOSPITAL ($1,000 penalty if Telligen is not called)	
Any inpatient stay in the hospital for medical, surgical, maternity, mental health or substance abuse care.	Call before elective admission or within two business days of an emergency admission.
Hospital outpatient treatment for mental health and substance abuse	Call before the treatment begins.
Plan pays nothing for the services listed below unless Telligen certifies	
AMBULANCE	
When an ambulance (or air ambulance) is used for transfer between hospitals or to a hospital in a non-emergency situation	Call before the transfer is arranged.
SURGERY	
Organ transplant surgery Bariatric surgery Cardiac Care Hip, knee, spine procedures } Must be done at a Blue Distinction Center or Blue Distinction Center + Gender reassignment surgery	Call before surgery is scheduled.
MEDICAL EQUIPMENT	
DME (durable medical equipment)	Call before equipment is ordered if more than $500 for each item.
OUTPATIENT THERAPY	
Mental health & substance abuse outpatient therapy/ counseling	Call after a combined total of 10 sessions from one or more providers. Call each year if care is on-going.
Occupational and speech therapy	Call after the 10th session each year from one or more providers. Call each year if care is on-going.
Physical therapy	Call after the 10th visit from one or more providers.
DIAGNOSTIC TESTS	
MRI, PET & CT scans - Outpatient	Call before test is done. Covered 100% if pre-certified and done at a free standing facility. Deductibles and co-insurance amounts apply if done at a hospital facility or billed by a hospital.
OTHER SERVICES	
Home health care	Call before services start.
Skilled nursing facility	Call before being admitted.
Sleep Study, Hospice, Infertility treatment, Non-surgical transplants, Other gender reassignment services	Call before services start.

PPO SAVINGS

SAVE BY USING DOCTORS AND HOSPITALS IN THE PPO TIER 1 NETWORK:

The PPO gives you freedom to choose from three different network tiers. You can select doctors and hospitals (providers) from Tier 1 for some of your care, and use Tier 2 or Tier 3 providers for other services. You pay the lowest deductible and coinsurance when you use providers in Tier 1. To find a Tier 1 provider, call 1-800-772-6895 or go to www.bcbsil.com/cityofchicago.

TWO WAYS TO SAVE ON PRESCRIPTION MEDICATIONS:

1. Choose generic medications and pay the lowest copay.
2. Use mail order for long term "maintenance" medications. You will pay more if you don't use mail order for long term medications after the 3rd fill. Just call 1-866-748-0028 and ask CVS Caremark to contact your doctor for a new prescription to be processed through mail order.

SAVE ON LAB TESTS – USE A FREE-STANDING LAB:

Get your routine lab tests paid in full by using a free-standing lab (such as a Quest lab) which is not affiliated with a hospital. Even if your doctor already has an arrangement with Quest, ask for a lab order for tests to be done at a Quest free-standing facility. Take this paperwork or the order form from your doctor to the free-standing Quest lab and test results will be sent directly to your doctor. Call 1-866-697-8378 to find the location of a Quest lab near you, or go to www.Questdiagnostics.com.

SAVE ON SCANS - USE A FREE-STANDING IMAGING CENTER:

Scans are covered in full if done at a free-standing imaging center. When your doctor orders an MRI, CT, or PET scan, call Telligen at 1-800-373-3727 to pre-certify the test and locate a free-standing imaging center near you.

PREGNANT? EARN A $100 INCENTIVE:

Enroll in a free, confidential maternity management program designed to encourage a healthy baby by providing telephone support for moms-to-be. To qualify for the $100 incentive, call Telligen 1-800-373-3727 to enroll and complete at least eight doctors' visits during the pregnancy.

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Administered by Blue Cross Blue Shield of Illinois

BLUE ADVANTAGE HMO* – A Blue Cross HMO

***HMO enrollment is available at the first open enrollment following 18 months of full-time City employment.**
If care is pre-approved by your HMO primary care physician (PCP), you pay the amount shown.

Service Type	You Pay
DOCTORS VISITS	
Primary Care Physician	**$25 copay**
Specialists	**$35 copay** when approved by PCP
Pre-natal visits	**$25 copay** first visit
HOSPITAL (all hospital services must be approved by PCP)	
Inpatient admission	**$100 copay per day first 5 days**
Surgery (inpatient & outpatient)	**$100 copay**
Maternity delivery	**$100 copay per day first 5 days**
Behavioral health inpatient care	**$100 copay per day first 5 days**
PREVENTIVE SERVICES	
Routine checkups for adults & children; well- baby care; well-women visits; mammograms; DRE & PSA; colonoscopies, hearing tests	**$0 copay**
EMERGENCY SERVICES (see next page for emergency coverage information)	
Emergency room treatment – life threatening	**$200 copay** (waived if admitted)
Ambulance – life threatening	**You pay $0**
MENTAL HEALTH & SUBSTANCE ABUSE (must be pre-approved by PCP)	
Outpatient therapy	**$25 copay**
OUTPATIENT REHAB THERAPY (must be pre-approved by PCP)	
Physical, speech and occupational therapy	**$0 copay** Limit of 60 visits combined each calendar year
OTHER SERVICES (all other services must be pre-approved by PCP)	
Skilled nursing facility	**$0** Limited to 120 days a year
Durable Medical Equipment (DME) Hospice Home health care Ambulance transport between hospitals	**$0**

www.bcbsil.com/cityofchicago • 1-800-730-8504

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HMO EMERGENCY CARE

The Blue Advantage HMO covers life threatening medical emergencies. It also covers care for acute medical problems when pre-approved by your primary care physician (PCP).

What is a medical emergency?

A life threatening medical emergency is the sudden and unexpected onset of a potentially dangerous situation which, if not treated immediately, could jeopardize your health. Such conditions are also severe and sudden in onset.

EMERGENCY ROOM TREATMENT Go to the nearest emergency room in the event of a life threatening emergency	You pay **$200 copay** – waived if admitted If possible, contact your PCP before seeking emergency care. (Your PCP is available 24 hours a day, seven days a week.) In a life threatening emergency, call your PCP within 48 hours following emergency care.
AMBULANCE For life threatening medical emergencies	You pay **$0**
TREATMENT IN PCP OFFICE For acute medical problems which are not life threatening	You pay **$25 copay** if care is given in your PCP's office. Call your PCP's emergency number on the back of your Blue Advantage HMO ID card. A doctor or nurse will listen to your problem and give instructions on where to go for medical care.
URGENT MEDICAL CARE AWAY FROM HOME For treatment for unexpected illness and injury when travelling outside the Chicagoland area contact your PCP.	Call the toll-free emergency number on the back of your Blue Advantage HMO ID card. If you or a covered dependent is away from home for more than 90 days, guest membership is provided at affiliate HMOs. Copays may be different.

***HMO enrollment is available at the first open enrollment following 18 months of full-time City employment.**

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HMO and PPO PRESCRIPTION DRUG PROGRAM

Administered by CVS Caremark

PRESCRIPTION MEDICATIONS	YOU PAY
RETAIL - Short term medications If purchased at a participating retail pharmacy 34 day supply or 100 units whichever is less	Generic **$11 copay** Preferred brand name **$31 copay** Non-preferred brand name **$46 copay**
RETAIL - Maintenance or long term medications The 4th fill and any additional refills 34 day supply or 100 units, whichever is less.	Generic $**21 copay** Preferred formulary brand name **$61 copay** Non-preferred brand name **$101 copay**
MAIL ORDER **Long term and maintenance medications for chronic conditions and specialty medication** 90 day supply To get medications through the mail, send your doctor's prescription to: CVS Caremark P.O. Box 94667 Palatine, IL 60094-4467 Call Caremark or visit its website, www.caremark.com, for more information about mail order.	Generic **$21 copay** Preferred brand name **$61 copay** Non-preferred formulary **$101 copay**
Generic birth control **Smoking Cessation medications**	**$0 copay**
Annual Rx Deductible	**$100 per household**

VALUE FORMULARY

Your plan has adopted Value Formulary to encourage use of generics. Prescriptions not on the Value Formulary list will be denied coverage at the pharmacy and the pharmacist will then ask your physician to substitute a Value Formulary drug.

If your physician does not agree to change the prescription, your physician must request an exception from CVS Caremark by submitting clinical information for prior authorization. An approval or a denial will be faxed to your physician and mailed to your home address. Call CVS Caremark or visit the website, www.caremark.com for information about the prior authorization process and the list of Value Formulary drugs.

www.caremark.com • 1-866-748-0028

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DENTAL PROGRAM

Administered by Blue Cross Blue Shield of Illinois

Enrollment in the dental plan is available after one calendar year of full-time employment. Separate contributions for dental coverage will be taken as payroll deductions. No action is needed if you want to continue your same dental coverage in 2022.

If you want to add or drop coverage or change dental plans for 2022, visit www.cityofchicagobenefits.org or call the Benefits Service Center at 1-877-299-5111 during open enrollment.

BLUE CARE DENTAL PPO & HMO BENEFITS

	PPO In-Network	PPO Out-of-Network	HMO In-Network*
	YOU PAY	**YOU PAY**	**YOU PAY**
Preventive (Two visits each year) **Oral exams** **Cleanings** **X-Rays**	**$10 copay** No deductible for preventive services	**20%** of PPO allowable amount plus balance of billed charges No deductible for preventative services	**$10 copay** for each preventive visit No deductible in the HMO
Annual deductible (amount each member pays first before plan pays benefits)	**YOU PAY** **$100**	YOU PAY **$200**	**YOU PAY** No deductible
Annual limit (maximum amount a member receives in dental coverage each year after deductible has been paid)	PLAN PAYS UP TO **$1,500**	PLAN PAYS UP TO **$1,500**	 No annual limit
	YOU PAY	YOU PAY	YOU PAY
Restorative **Endodontics** **Periodontics** **Oral Surgery** **Crowns**	**20%** **20%** **20%** **40%** **40%**	**50%** of PPO allowed amount plus balance of billed charges	Copays of various amounts (for information about co-pay amounts visit www.bcbsil.com/cityofchicago or call 1-855- 557-5487). Plan pays **100%** after co-pay
Orthodontics	Not covered	Not covered	Covered for children of sworn police and uniformed firefighters up to age 25 with **$1,800** copay. Coverage limited to age 19 for all others with **$1,800** copay. Not covered for employee or spouse

*There is no out-of-network coverage in the Dental HMO. You must use dentists who participate in the Dental HMO. For up-to-date information about HMO dentists visit the dental program website or call for more information.

www.bcbsil.com/cityofchicago • 1-855-557-5487

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VISION PROGRAM

Administered by Davis Vision

You pay separate contributions for vision coverage which will be taken as payroll deductions. No action is needed if you want to continue your same vision coverage for 2022. If you want to drop vision coverage for 2022, visit www.cityofchicagobenefits.org or call the Benefits Service Center at 1-877-299-5111 during open enrollment.

The Vision Program is administered by Davis Vision and covers routine eye exams, as well as prescription eyeglasses or contact lenses. How much the plan pays depends on the type of services or eye-wear you choose and which vision retail store you use.

You get the most value from your vision benefits when you use a provider in the Davis Vision network. To locate Davis Vision providers visit www.davisvision.com or call 1-888-456-8758.

The Vision Program does not issue ID cards. Your Blue Cross Blue Shield ID or a State ID will be used to verify coverage in the Davis Vision plan.

DAVIS VISION CARE BENEFITS	In-Network You Pay	Out-of--Network You Pay
Routine Eye Exam (One exam every 12 months) based on last date of service	**$0**	Balance over **$35**
Frames One pair every 12 months	**$0** for frames from exclusive collection: • Or balance over the **$110** allowance for frames at Visionworks stores • Or balance over the **$50** allowance for frames at other in-network stores	Balance over **$50**
Lenses-single vision **Scratch Coatings** **Special lenses**	**$0** one set every 12 months **$0 copays** Visit www.davisvision.com or call 1-888-456-8758 for specific copay amounts.	Balance over **$35**
Contact lenses (in lieu of glasses)	**$0** one set every 12 months *Davis Vision collection **$0** for 4 multipacks or boxes *Other disposables: Balance over **$105**	Balance over **$105**

www.davisvision.com • 1-888-456-8758

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SIGN UP FOR FLEXIBLE SPENDING ACCOUNT (FSA)

(Healthcare and Dependent Care)

Administered by ConnectYourCare / Optum Financial

You must sign up for the FSA each year during Open Enrollment

WHAT IS AN FSA?

A Flexible Spending Account (FSA) is a tax-advantaged account that allows you to use pre-tax dollars to pay for qualified medical or dependent care expenses. You choose how much money you want to contribute to an FSA at the beginning of each year and can access these funds throughout the year. This contribution is subject to certain legal limits. There are minimum and maximum contribution requirements. More information is provided below.

HEALTHCARE FSA SUMMARY

- **MULTIPLE USES.** There are hundreds of eligible expenses for your FSA funds, including prescriptions, some over-the-counter items, doctor office copays, health insurance deductibles and coinsurance. FSA funds may even be used for eligible expenses for your spouse or federal tax dependents.

- **EASY TO ACCESS.** Funds in the account are easily accessed with the payment card. Your account balance is available at any time **online**, through the mobile app, or over the phone.

- **TAX ADVANTAGES.** Since FSA contributions are not taxed, you can reduce your taxable income by the amount you contribute to your FSA. You can then use those pre-tax dollars to pay for eligible health care expenses that would have otherwise been paid with post-tax dollars.

- **RAPID REIMBURSEMENTS.** Paying for health care expenses is easy when you use your payment card. If you do not use your card, you can quickly and easily create your claim **online**. Once you submit your receipts, you will be reimbursed via check or direct deposit.

USE IT OR LOSE IT

The IRS requires that any money left in your account at the end of the year will be forfeited, after a grace period. For 2022 the grace period ends March 15, 2023. You will have until March 31, 2023 to submit your 2022 expenses.

ELIGIBLE EXPENSES

The IRS requires that all FSA purchases be verified as eligible expenses. Sometimes, purchases are automatically verified when you use your payment card. Other times, you will need to submit itemized receipts or medical claims information . **Always save your itemized receipts!**

•Beginning January 1, 2022, **Healthcare FSA contributions are limited by the IRS to $2,750 each year.** The limit is per person; a husband and wife may each contribute up to the limit.

•The IRS requires that employers make the full annual Health FSA election available to employees when an eligible expense occurs, regardless of whether you have deposited enough to cover the full amount at that point in time.

For example, let's say you choose to contribute $1,200 per year, equal to a payroll deduction of $100 a month. You are eligible for reimbursement up to the full $1,200 in the first month, even though you have only deposited $100 in your account. Remaining deductions will be taken from your pay during the rest of the plan year.

MINIMUM/MAXIMUM CONTRIBUTIONS TO THE HEALTH CARE FSA

To participate in the Healthcare FSA, you must contribute a minimum of $120 and up to a maximum of $2,750 per calendar year. The Internal Revenue Service may increase the maximum amount.

The annual pledge amount will be divided equally among each pay period for the calendar year.

www.connectyourcare.com/cityofchicago • 1-833-229-4428

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DEPENDENT CARE FSA SUMMARY

You may also choose to enroll in a Dependent Care Account, which is an alternative to the Dependent Care Tax Credit and covers dependents (up to the age of 13) and certain elder care expenses while you are at work (special requirements apply).

A Dependent Care Account allows you to pay for expenses and you may have a tax break. Expenses must be for qualifying dependents. Typical expenses under this account include charges for day care, nursery school, and certain elder care (unless it is for medical care) for your legal dependents.

ELIGIBILITY REQUIREMENTS

To be reimbursed through your Dependent Care Account for child and dependent care expenses, you must meet the following conditions:

- You must have incurred the expenses in order for you and your spouse, if married, to work or look for work, unless your spouse was either a full-time student or was physically or mentally incapable of self-care.
- You cannot have made the care payments to someone you can claim as your dependent on your federal tax return or to your child who is under age 19.
- Your filing status must be single, qualifying widow(er) with a dependent child, married filing jointly, or married filing separately.
- You and your spouse must maintain a home that you live in for more than half the year with the qualifying child or dependent.
- Unlike the health FSA, you must use all of your Dependent Care FSA funds by the end of your plan year, or remaining funds will be forfeited, according to IRS regulations
- According to the IRS, you may contribute up to $5,000 per year if you are married and filing a joint return, or if you are a single parent. If you are married and filing separately, you may contribute up to $2,500 per year per parent.
- Unlike the health FSA, you may only receive reimbursement from your Dependent Care FSA equal to the amount you have actually deposited.

MINIMUM/MAXIMUM CONTRIBUTIONS TO THE DEPENDENT CARE FSA

To participate in the Dependent Care FSA, you must contribute a minimum of $120 annually. IRS rules limit the amount of money you can put in a dependent care FSA each calendar year. You may contribute up to the lesser of:

- $5,000 per plan year ($2,500 if you are married and filing a separate income tax return)
- Your spouse's total earned income (you may not contribute to the dependent care FSA if your spouse's earned income is $0 and your spouse is capable of self-care or is not a full-time student).

The annual goal amount will be divided equally among each pay period for the calendar year.

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PROTECT YOUR FUTURE INCOME FOR YOU AND YOUR LOVED ONES

The City at no cost to you, provides basic term life insurance. You have an opportunity to buy more coverage through the City's group insurance policy. You may contact the insurance providers at any time to learn more.

BASIC TERM LIFE INSURANCE: (MetLife www.metlife.com/mybenefits or 1-866-492-6983)

As a City employee, you automatically receive $25,000 of free basic life insurance which pays in the event of your death and/or for certain accidental losses. When your employment with the City ends, you can continue this basic life insurance by paying premiums directly to MetLife.

OTHER INSURANCE OPTIONS: Employees pay the full cost of coverage via payroll deductions.

OPTIONAL TERM LIFE INSURANCE: (MetLife www.metlife.com/mybenefits or 1-866-492-6983)

During open enrollment you may increase the amount of life insurance for yourself or buy coverage for your eligible dependents. Proof of good health may be required.

Please note:

- Proof of good health may be required if you are increasing the amount of insurance (1x to 10x your annual earnings, up to $1.5 million).
- Insurance is available for purchase for a spouse or civil union partner for $10,000, $25,000 or $50,000 of coverage (limits apply)
- Insurance is available for children from birth to age 25 for $5,000 to $10,000 in coverage (one rate covers all your children and no proof of good health is required)

VOLUNTARY PERMANENT LIFE INSURANCE: (Texas Life (formerly MetLife) www.empben.com/CityofChicagoUL/ or 1 -800-638-6855)

Permanent life insurance also provides a death benefit. Sign up during the open enrollment period and/or apply for coverage for your dependents. Proof of good health is required satisfactory to Texas Life.

LONG TERM DISABILITY (LTD): (Prudential www.prudential.com 1-800-842-1718)

The LTD is designed to provide you a monthly cash payment in the event you cannot work because of an illness or injury. Proof of good health is not required when you sign up during open enrollment.

Note: New City employees are automatically enrolled in Long Term Disability coverage. An employee may opt out of the program by contacting Prudential directly at the number above.

VOLUNTARY SUPPLEMENTAL INSURANCE

Employees will have the opportunity to purchase voluntary supplemental insurance through payroll deduction. Voluntary Supplemental Insurance is available through two insurance companies:

- Combined Insurance Company, www.combinedinsurance.com/cityofchicago, 1-888-870-3382
- Aflac Insurance Company, www.aflac.com/cityofchicago, 1-888-382-3522

Each insurer is authorized to enroll you in one of three supplemental insurance products:

- Hospital Indemnity Insurance pays a fixed dollar amount if you are hospitalized.
- Accidental Injury Insurance pays a fixed dollar amount for certain medical and other services if you are injured in a non-work accident.
- Critical Care insurance pays a fixed dollar amount if you become ill with a specified critical diagnosis.

Employees should carefully consider which of the optional products the City offers best meets their needs for life insurance, disability insurance, medical and dental care and supplemental insurance through payroll deduction.

Detailed information about these products is available directly from the insurers at the numbers listed above. Additional information will be sent to your home by the insurers. *The City of Chicago Benefits Office does not provide advice regarding these insurance products.*

DEFERRED COMPENSATION RETIREMENT PLAN

Administered by Nationwide

The Deferred Compensation program can help you save for retirement. Don't wait until you are approaching retirement, start now and enjoy immediate tax savings. Contributions accumulate with interest, earnings and investment gains or losses. Even if you are only investing a small amount each pay period, it will add up over time. Enroll now and start saving.

Minimum payroll deduction to start account	$10 per pay period
Contribution limits if you are under age 50	$19,500* for 2021 (may be increased by IRS for 2022)
Contribution limits if you are over age 50	Additional "catch-up" contribution of $6,500 permitted, for a total of $26,000 in 2021* (IRS may increase for 2022)
Age at which you must begin taking distributions	April 1st of the year following the year when you attain 72 or end employment with the City of Chicago, whichever is later.
Penalty for early withdrawals	Beginning at attainment of age 59 ½ you may withdraw funds prior to ending your employment with City of Chicago. Funds rolled over from an IRA or qualified retirement plan may be subject to early withdrawal penalty if withdrawn prior to 59 ½
Accessing funds while still employed	You may access your funds if you: • Have $5,000 or less in your account, have not contributed to the plan in at least two years and have never taken a withdrawal of this type before • Take a plan loan • Request an unforeseeable emergency withdrawal (requires approval according to IRS guidelines) • Request up to $5,000 within 12 months of a qualified birth or adoption
Taxation	Distributions are subject to income tax unless rolled over to an IRA or a qualified retirement plan. Not all distributions are eligible for rollover.
Matching Contribution	Some collective bargaining agreements provide for employee matching contributions into a 401(a) Match Plan. See your collective bargaining agreement for details

www.chicagodeferredcomp.com • 1-855-457-2489 or 1-877-677-3678

*These numbers are subject to change annually

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Well OnTarget® (www.wellontarget.com)

Well onTarget® is the wellness program offered by Blue Cross Blue Shield of Illinois. Well onTarget® includes a Health Assessment, self-management programs, tracking tools and interactive health calculators, and a variety of trusted health resources and information. Your participation in Well onTarget® is completely optional and will not impact the premium you pay for health insurance.

Well onTarget® also offers reduced price gym memberships, and the Blue Points Program® which allows members to earn reward points which can be redeemed in an on-line shopping mall. For example, if you complete a Health Assessment once every six months you will earn 2,500 rewards points each time which you can redeem in the on-line shopping mall. You can earn reward points for completing health related education programs and engaging in physical activities or you can sync many fitness devices and earn points automatically.

Well onTarget® is available at www.wellontarget.com. You will need your BCBSIL medical plan identification card to enroll. If you are already a member for Blue Access for Members (BAM), you will use your BAM credentials to sign in. Please call 1-877-806-9380 between 7:00 a.m. - 9:00 p.m. CT for any questions on the program.

Health Improvement Programs (HIP)

There is an additional component to the Chicago Lives Healthy Wellness Program called a Health Improvement Program. If you are notified that you have been assigned to participate in a Health Improvement Program (HIP), the participation requirements will differ by program but will generally include an enrollment session and then coaching sessions during the quarter. You will meet ongoing HIP participation requirements by engaging with the health professionals who provide coaching service through the programs.

Members are identified for HIP based on a variety of factors including biometric screening results and for Blue Choice Options (PPO) participants, pharmacy and medical claim data. Participation in a HIP does not require you to meet any physical performance goals such as a reduction in blood pressure, weight or cholesterol readings. With the support and guidance of a health coach, you will learn about your risk factors and how to make progress towards improving your health. You can also discuss goals and strategies to better your health, plus benefit from the expertise coaching provides.

This is a voluntary wellness program and you can elect to participate or chose not to participate. However, if the HIP participation requirements are not met, there will be a $50 per non-participant per month increase in the employee's required health plan contribution. For example, if both the covered spouse and the employee are assigned to a HIP program and elect to not participate, the employee will pay $100 more per month for health plan coverage.

If you are assigned to a HIP for 2022, you will receive an individual letter early in January 2022 that will provide program specifics, participation requirements, and enrollment information.

REMINDERS

A REMINDER ABOUT FRAUD

Any kind of fraud on the City of Chicago's benefit plans may result in adverse consequences to an employee and dependent, for example:

- Failure to notify the City Benefits Service Center of an event that would cause coverage to end, e.g. divorce.
- Misrepresentation by the employee or dependent regarding the initial eligibility, for example, the dependent's age, or that the dependent is not a legal dependent of the employee.
- Any attempt to assign or transfer coverage to someone else (e.g. letting another person use your Plan ID card).

The employee will be required to pay for any claims and all administrative costs that were incurred fraudulently. This may result in coverage being terminated for the employee and action by the City to collect any money paid. The City may also discipline the employee, up to and including termination.

DIVORCED SPOUSE'S HEALTH COVERAGE

If an employee becomes divorced, he/she must follow the procedure outlined in the City's Plan document available at www.cityofchicagobenefits.org **which includes notifying the Benefits Service Center online (or by calling) within 30 days of the date of the divorce, and by submitting the certified divorce decree.**

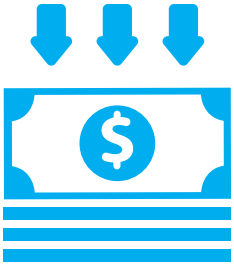
To notify the Chicago Benefits Center **online,** log in at **www.cityofchicagobenefits.org**, click on "Life Events" then select "Divorce" and follow the prompts. To notify by phone, call 1-877-299-5111. **Review the City's plan document at the website above for more information.**

Failure to comply with the procedure will result in the employee being held liable for any healthcare claims and related expenses incurred by the ex-spouse as of the date of the divorce.

Chicago Benefits Office
333 South State Street
Suite 400
Chicago 60604-3978

Office hours are Monday through Friday 8:30 a.m. – 4:30 p.m.

If your documents are uploaded, the Chicago Benefits Office reserves the right to request original certified eligibility documents.



ONLINE PAY SLIPS

Sign up for GreenSlips, the City online pay slips program to view direct deposit of your paycheck online. You can also view and download your W2 tax return as soon as available.

Go to https://greenslips.cityofchicago.org/TransformContentCenter/ and use your employee number to set up a secure account.

2022 IMPORTANT WEBSITES AND PHONE NUMBERS

SERVICE PROVIDER	WEBSITE	PHONE NUMBER
City of Chicago Benefits Service Center	www.cityofchicagobenefits.org	1-877-299-5111
Medical PPO Blue Cross Blue Shield of Illinois	www.bcbsil.com/cityofchicago	1-800-772-6895
CVS Caremark Pharmacy	www.caremark.com	1-866-748-0028
Telligen medical plan advisor	thms.qualitrac.com	1-800-373-3727
Medical HMO Blue Advantage HMO	www.bcbsil.com/cityofchicago	1-800-730-8504
CVS Caremark Pharmacy	www.caremark.com	1-866-748-0028
BlueCare Dental Dental PPO and HMO	www.bcbsil.com/cityofchicago	1-855-557-5487
Davis Vision	www.davisvision.com	1-888-456-8758
Quest Diagnostics	www.questdiagnostics.com	1-866-697-8378
MetLife Basic term life insurance Optional life insurance	www.metlife.com/mybenefits	1-866-492-6983
Prudential Long Term disability	www.prudential.com	1-800-842-1718
Texas Life Universal permanent life insurance	www.empben.com/CityofChicagoUL/	1-800-638-6855
Nationwide Retirement Services	www.chicagodeferredcomp.com	1-877-677-3678
Voluntary Supplemental Insurance Combined Insurance Company Aflac Insurance Company	www.combinedinsurance.com/cityofchicago www.aflac.com/cityofchicago	1-888-870-3382 1-888-382-3522
ConnectYourCare/Optum Financial Flexible Spending Account (FSA) Dependent Care Account Transit Benefit Program	www.connectyourcare.com/cityofchicago	1-833-229-4428
Chicago Lives Healthy Wellness Program: Well on Target Health Improvement Program (HIP)	www.wellontarget.com thms.qualitrac.com	1-877-806-9380 1-800-373-3727

Plan C effective 1/1/2022. This is a summary of benefits offered to City Employees (excluding Sworn Police Officers below the rank of Sergeant and Seasonal Employees). The Plan Document and subsequent updates always supersede this summary.

2022 IMPORTANT WEBSITES AND PHONE NUMBERS

SERVICE PROVIDER	WEBSITE	PHONE NUMBER
Firemen's Annuity and Benefit Fund of Chicago	www.fabf.org	1-312-726-5823
Policemen's Annuity and Benefit Fund of Chicago	www.chipabf.org	1-312-744-3891
Municipal Employees' Annuity and Benefit Fund of Chicago	www.meabf.org	1-312-236-4700
Laborers' and Retirement Board Employees' Annuity and Benefit Fund of Chicago	www.labfchicago.org	1-312-236-2065

CITY OF CHICAGO
MEDICAL PPO PLANS ("MEDICAL PLANS")

NOTICE TO ENROLLEES OF MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT EXEMPTION FOR 2022

Generally, group health plans sponsored by state and local governmental employers, such as the City of Chicago (the "City" or "plan sponsor") must comply with federal law requirements in title XXVII of the Public Health Service Act, and the amendments thereto set forth in the Mental Health Parity and Addiction Equity Act. However, these governmental employers are permitted to elect to exempt a plan from all of the requirements listed below for any part of the plan that is self-funded by the employer rather than provided through a health insurance policy. The purpose of this Notice is to inform you that the City of Chicago has elected to exempt the City of Chicago Medical PPO Plans as follows:

1. Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan (sometimes referred to as "mental health parity requirements"). The plan sponsor has elected to maintain the existing terms and conditions of the Medical Plans by exempting the Medical Plans from this requirement. Therefore, the City will continue in place the current requirement that Plan Participants who receive outpatient mental health and substance abuse treatment by a behavioral health specialist must obtain pre-certification by a Medical Advisor, under the Plans' Medical Advisor Review Program, after the first ten sessions each year with one or more such providers. This requirement will continue in effect for the 2022 plan year (beginning January 1, 2022, and ending December 31, 2022), and may be renewed for subsequent plan years pursuant to a subsequent exemption election, unless modified through the collective bargaining process.

2. Protection against limiting hospital stays in connection with the birth of a child to less than 48 hours for a vaginal delivery, and 96 hours for a cesarean section. The Medical Plans currently meet this requirement and thus this requirement will continue to apply under the terms of the Medical Plans without exception.

3. Certain requirements to provide benefits for breast reconstruction after a mastectomy. The Medical Plans currently meet this requirement and thus this requirement will continue to apply under the terms of the Medical Plans without exception.

4. Continued coverage for up to one year for a dependent child who is covered as a dependent under the plan solely based on student status, who takes a medically necessary leave of absence from a postsecondary educational institution. The Medical Plans no longer use student status and provides an opportunity to elect coverage to age 26 and thus this requirement currently applies under the terms of the Medical Plans without exception.

ANNUAL HEALTHCARE REMINDER

As required by the Women's Health and Cancer Rights Act of 1998, each medical plan offered by the City of Chicago provides benefits for mastectomy related services including reconstruction and surgery to achieve symmetry between breasts, as well as prostheses and complications resulting from a mastectomy (including lymphedema). Contact your PPO or HMO administrator for more information.

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