

CITY OF CHICAGO
MEDICAL PPO PLAN FOR EMPLOYEES

Effective January 1, 2013

For non-represented Employees, and for Employees covered under the City's collective bargaining agreements with: AFSCME, Coalition of Unionized Public Employees (Chicago Building Trades Coalition), INA, Unit II, Police Captains Association, and the Police Lieutenants Association; police sergeants represented by the Policemen's Benevolent & Protective Association of Illinois (PB&PA); supervising police communications operators represented by Teamsters Local 727; 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.

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I. INTRODUCTION

Please read this entire PPO booklet at least once. It will help you to be generally familiar with the medical Preferred Provider Organization (PPO) Plan benefits offered by the City. If you know the rules and follow them, you may be able to reduce your out-of-pocket costs for health care. Following this page is a Quick Guide to this PPO booklet, which provides a list of the typical questions asked about the medical PPO Plan and where to find answers. The Quick Guide is not intended to be a substitute for reading the PPO booklet; it is intended to help you locate answers to your most important questions quickly. Following the Quick Guide is the Life Events (also known as Family Status Changes) section, which provides guidance on what to do when certain life events occur. It's just one more way to find information quickly in the PPO booklet.

The Definitions section is in the back of this booklet (starting on 109). Defined terms are capitalized throughout the PPO booklet. To look up a definition, go to the Definitions section and search alphabetically.

The City provides comprehensive health care protection for you and your Family. You have the option to select between an HMO plan and a PPO plan. This document provides information about the City's Medical PPO Plan (the "Plan"). Additional information about other medical plan options and other benefits provided by the City may be found on the City's website at www.cityofchicago.org/benefits. The Plan features:

- Access to the PPO network, which consists of Doctors and Hospitals nationwide (Plan benefits are higher if you use the PPO network);
- Preventive care benefits; and
- Prescription drug benefits.

Limitations apply to your coverage for speech and occupational therapy, and Certification by the Medical Advisor is required for MRI, PET scans, and CAT scans. More information is provided later in this document regarding the services that require precertification and the applicable limitations.

In addition, the Plan's Medical Advisor Review Program must be notified 24 hours before an elective Hospital admission or within two business days after an emergency admission. There is a financial penalty applied to your Hospital bill for failure to call, so contact the Medical Advisor, toll-free, at the number listed in Section V. These are just a few examples of the procedures and services required to be pre-Certified by the Medical Advisor, for further information, it is important that you review the section entitled "Medical Advisor Review Program."

It is important that you keep the Plan Administrator (the City of Chicago) informed about changes in your status or in the status of a Dependent that is covered by the Plan. For example, you must notify the Plan about a change in a Dependent's status or the death or divorce of a Dependent. Note that you must notify the City's Human Resources Department of any change in address. Keep in mind that many changes can have an impact on your monthly contribution rate for coverage, how your claims are paid, or who is responsible for the payment of the claim. If you fail to inform the Plan Administrator about certain events, you may lose the right to

continuation coverage under the Public Health Services Act (see page 30). In addition, if you or your Dependent deliberately defraud or mislead the Plan Administrator about your eligibility or that of your Dependents, you and your Dependents will become ineligible for benefits effective immediately and possibly retroactively.

The City adopted this restatement of the Plan effective January 1, 2011. The Plan has been established to provide health care benefits to Employees and their Dependents. The benefits described on the following pages are sponsored by the City (Plan Sponsor).

Please take some time to review this PPO booklet, and share the information in this PPO booklet with your covered adult Dependents. Contact the Benefits Service Center by phone at 877-299-5111, if you have any questions about the benefits described in this PPO booklet.

A list of information resources is provided with this PPO booklet in the “Important Contact Information” section on page 11.

II. QUICK GUIDE

<i>If I want to know. . .</i>	See Page:
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III. LIFE EVENTS

Note: This Life Events Section applies to both participants in this Plan (the PPO Plan) and also to participants in the HMO Plan. Accordingly, there may be references to the HMO or to HMO/insurance law requirements that do not apply to this Plan.

Different life events can affect your benefits coverage. This section describes how your coverage may be affected and what you may need to do when different events occur. For more information, please contact the Benefits Service Center at 877-299-5111, or by email at benefitshelp@cityofchicago.org.

A. Marriage, Civil Union, or Domestic Partnership

When you marry, enter into a civil union or domestic partnership, your Spouse, Civil Union Spouse or Domestic Partner is eligible for medical coverage, including prescription drug coverage, as of the date of your marriage, civil union or satisfaction of Domestic Partner requirements. However, the Plan will not pay any benefits on behalf of your Spouse, Civil Union Spouse, or Domestic Partner until you enroll your Spouse, Civil Union Spouse, or Domestic Partner for coverage. You must enroll your Spouse or Civil Union Spouse within 30 days of your marriage or civil union and supply Proof of Dependency. You must enroll your Domestic Partner within 30 days of certification of the partnership. See page 14 for more information on adding your Spouse, Civil Union or Domestic Partner Spouse to your coverage.

B. Adding a Child

Your natural child will be eligible for coverage on the date of birth. If you adopt a child, have a child placed with you for adoption or become a legal guardian for a child, he or she may be eligible for coverage on the date of placement so long as the child otherwise meets the Plan's definition of a Dependent child. Stepchildren may be eligible for coverage on the date of your marriage. See page 14.

However, you must enroll your child for coverage within 30 days of acquiring that child and provide a certified birth certificate and other documentation of dependency within the required time frames before the Plan pays any benefits for that child. See Proof of Dependency on page 18 for more information on adding your child to your coverage.

C. Getting Divorced, Dissolving a Civil Union or Domestic Partnership

If you and your Spouse or Domestic Partner get a divorce or you dissolve your civil union or domestic partnership, your Spouse, Civil Union Spouse or Domestic Partner will no longer be eligible for coverage. You must notify the City immediately of a divorce or dissolution. However, a divorced Spouse may elect to continue coverage under the Public Health Service Act (PHSA) COBRA for up to 36 months as set forth on page 30. You or your ex-Spouse must notify the Benefits Service Center within 60 days of the divorce for your spouse to obtain this continuation coverage for up to 36 months. Domestic Partners and Civil Union Spouses may not be eligible for continuation. See page 30 for more information.

If your ex-spouse, ex-Civil Union Spouse, or ex-Domestic Partner has claims paid after the effective date of the divorce or dissolution, you will be responsible for reimbursing the City

for either the claims (for PPO Plan participants) or premiums (for HMO participants) paid on behalf of the ex-spouse.

D. Child Losing Eligibility

In general, your Dependent child is no longer eligible for coverage when he or she reaches the limiting age or no longer meets the definition of “Dependent” under the Plan. See page 113. You should notify the Benefits Service Center when one of these events occurs.

Your child may elect to continue coverage under PHSA COBRA for up to 36 months. You or your child must notify the Benefits Service Center within 60 days of the date your child no longer meets the eligibility requirements in order to obtain this continuation coverage.

E. Taking a Family Medical Leave of Absence

The Family and Medical Leave Act (FMLA) allows you to take a certain amount of unpaid leave during any 12-month period, if you qualify, due to specific reasons. Employees on FMLA leave are entitled to the same health benefits coverage from the City during the leave under the same conditions as if they were working.

F. Military Leave

Under the Uniformed Services Employment and Reemployment Rights Act (“USERRA”), you may continue coverage for up to 24 months if you are absent from work due to qualified military service.

G. In the Event of Death

In the event of your death, your Spouse and eligible Dependent children may continue coverage for up to 36 months by electing continuation coverage through PHSA COBRA (see page 30).

H. Returning to Work after a Leave of Absence

When you return to work after an approved leave of absence, you must complete enrollment by calling the Benefits Service Center to reinstate your coverage. You have 30 days from the date you return to work to complete enrollment; otherwise you will have to wait until the next open enrollment period to enroll for coverage for the next January 1.

IV. PPO PLAN SCHEDULE OF BENEFITS

The following chart highlights key features of the Plan. These benefits are described in detail in this PPO booklet. The Plan pays the following percentage of Allowable Charges after you meet the Deductible.

Medical Benefits	PPO Provider	Non-PPO Provider
Deductible Each Year		
Individual	\$350	\$1,500
Family	\$1,050	\$3,000
Out-of-Pocket Limit Each Year		
Individual	\$1,500	\$3,500
Family	\$3,000	\$7,000
<i>Network and Non-PPO Provider benefits cannot be combined; does not include any Copayments</i>		
Preventive Service Benefits		
- Certain Contraceptive Medications and Devices (e.g., IUD, diaphragm) if prescribed	100% of Allowable Charges	Not Covered
- Certain Smoking Cessation Medications		
- Additional Recommended Preventive Services to the extent required to be covered under the Affordable Care Act of 2010 (also known as the health care reform legislation); for a list of other covered preventive services, please visit www.healthcare.gov/prevention/index.html.		

Outpatient Services	PPO Provider	Non-PPO Provider
- Diagnostic Testing (e.g., X-ray, lab, etc.) ⁽⁵⁾	90%	60%
- Outpatient Surgery	90%	60%
- Physical Therapy	90%	60%
- MRI Scans, PET Scans, CAT Scans ⁽¹⁾⁽⁵⁾	90%	60%
- Durable Medical Equipment (if over \$500, subject to Pre-Certification ⁽¹⁾)	90%	60%
- Prosthetic Appliances, such as artificial limbs or eyes	90%	60%
- Skilled Home Health Care and Hospice Care ⁽¹⁾	90%	60%
- Infertility Treatment ⁽¹⁾	90%	60%
- Ambulance Transportation between Hospitals ⁽¹⁾	90%	60%
- Physician Office Visit	\$25 Copayment for Primary Care visit \$35 Copayment for Specialist visit	60%
- Occupational and Speech Therapy ⁽²⁾	\$20 Copayment per visit (annual 60 visit maximum for each)	60%
- Chiropractic office visits for manipulation (maximum 20 per year; three Modalities per visit)	\$35 Copayment per visit	60%

Organ Transplants	PPO- Approved Transplant Center	Non-Approved Transplant Center
The following organ transplants must be performed at an approved transplant center or they are not covered. You must call the Medical Advisor for Pre-Certification.		
- Heart ⁽¹⁾⁽⁴⁾	90%	Not Covered
- Combination Heart/Bilateral Lung ⁽¹⁾⁽⁴⁾	90%	Not Covered
- Simultaneous Pancreas Kidney ⁽¹⁾⁽⁴⁾	90%	Not Covered
- Kidney only in conjunction with SPK/PAK ⁽¹⁾⁽⁴⁾	90%	Not Covered
- Bone Marrow ⁽¹⁾⁽⁴⁾	90%	Not Covered
- Stem Cell (autologous and allogeneic) ⁽¹⁾⁽⁴⁾	90%	Not Covered
- Lung ⁽¹⁾⁽⁴⁾	90%	Not Covered
- Liver ⁽¹⁾⁽⁴⁾	90%	Not Covered
- Pancreas (PAK/PAT) ⁽¹⁾⁽⁴⁾	90%	Not Covered
- All Other Organ Transplants ⁽¹⁾	90%	60%

- (1) These services require Pre-Certification by Medical Advisor. Call 1-800-373-3727.
- (2) After 10 therapy visits, Pre-Certification by Medical Advisor is required. Call 1-800-373-3727. All speech and occupational therapy visits have a \$20 Copayment (therapy only) per visit. Copayment does not apply toward Deductible or Out-of-Pocket Limit. Maximum of 60 visits annually for speech therapy. Maximum of 60 visits annually for occupational therapy.
- (3) These services require Pre-Certification by Medical Advisor after the first seven sessions in any one year with one or more Providers.
- (4) These services must be performed at an approved transplant or bariatric center.
- (5) Plan will pay 100% for certain PPO Provider diagnostic testing and MRI/CAT/PET scans if Participant meets the requirements of the Diagnostic Testing Incentive Program as set forth under Diagnostic Testing in Article VIII "How the Medical Plan Works."

Hospital	PPO Provider	Non-PPO Provider
- Room and Board (private room covered if Medically Necessary) ⁽¹⁾	90%	60%
- Inpatient Hospital Services ⁽¹⁾	90%	60%
- Outpatient Hospital Services	90%	60%
- Skilled Nursing Facility ⁽¹⁾	90%	60%

Bariatric Surgery	PPO-Approved Bariatric Provider	Non-Approved Bariatric Provider
<u>Bariatric surgery must be performed at an approved bariatric center. Otherwise, the surgery is not covered. You must call the Medical Advisor for Pre-Certification.</u>		
- Bariatric Surgery ⁽¹⁾⁽³⁾	<u>90%</u>	<u>Not Covered</u>

Maternity	PPO Provider	Non-PPO Provider
- Maternity (delivery ⁽¹⁾ , prenatal visits, and postnatal visit)	90%	60%

Emergency		
- Emergency Room Copayment	\$100 per visit; waived if admitted as an in-patient. The Copayment does not apply toward the Deductible or Out-of-Pocket Limit.	
- Emergency Medical or Emergency Accident Care	90%	90%

Mental Health and Substance Abuse Treatment	PPO Provider	Non-PPO Provider
- Outpatient Mental Health and Substance Abuse ⁽²⁾ treatment by a Behavioral Health Specialist	\$25 Copayment	60%
- Inpatient Mental Health and Substance Abuse Treatment ⁽¹⁾	90%	60%

(1) These services require Pre-Certification by Medical Advisor. Call 1-800-373-3727.
(2) These services require Pre-Certification by Medical Advisor after the first seven sessions each year with one or more Providers.
(3) These services must be performed at an approved transplant or bariatric center.

Prescription Drug Benefits

At a Participating Pharmacy:	Generic: \$10 copay
- Retail (Short term medications; Maintenance/ Long Term Medications – less than 4 refills; 34-day supply or 100 units, whichever is less)	Brand Name (Formulary) \$30 copay* ** Brand Name (Non-Formulary) \$45 copay* **
- Retail (Maintenance/Long Term medications – 4 th refill and any additional refills; 34-day supply or 100 units, whichever is less)	Generic: \$20 copay Brand Name (Formulary) \$60 copay* Brand Name (Non-Formulary) \$90 copay*
- Mail Order (Maintenance/Long Term Medications for chronic conditions; 90 day supply)	Generic: \$20 copay Brand Name (Formulary) \$60 copay* Brand Name (Non-Formulary) \$100 copay*

**If the member chooses a brand name drug when a direct generic equivalent is available, member pays the cost difference between the brand name and the generic drug PLUS the generic Copayment.*

***Where there is no direct generic equivalent available, but there are generic or preferred specialty drugs in the same class, the Generic Step Therapy/Specialty Drug Preferred Therapy Program applies. Under this program you may be required to try an available generic or a preferred formulary specialty drug in the same class of drugs; if you do not try the generic or preferred formulary specialty drug as required, you will pay the full cost of the brand name drug. If you do try the drug and your Physician finds that it is not effective, you then may receive coverage for the brand drug based on the schedule set forth here.*

At a Non-Participating Pharmacy:

If you obtain prescriptions from a non-participating pharmacy, benefits will be paid at:

- 60% of the Plan's cost for generic drugs and for brand name drugs when a generic equivalent is not available, and
- 60% of the Plan's generic drug cost when you get a brand name drug that has a generic equivalent available.

V. IMPORTANT CONTACT INFORMATION

Below is contact information for the various organizations that provide services and/or insurance under either this Plan (the PPO Plan) or other City plans, as identified. Contact information also will be available at www.cityofchicagobenefits.org, and will be included with annual open enrollment materials.

IMPORTANT WEB SITES, TELEPHONE NUMBERS, AND ADDRESSES				
Plan Eligibility and Enrollment	City of Chicago Benefits Service Center	www.cityofchicagobenefits.org	1-877-288-5111	333 S. State Street, Room 400 Chicago, IL 60604-3978
Medical Plans	Blue Cross and Blue Shield of Illinois	www.bcbsil.com	1-800-772-6895	(For Claim Processing) 300 East Randolph Street Chicago, IL 60601-5099
PPO Plan Claims Administrator Blue Advantage HMO			1-800-730-8504 Fax: 1-918-551-2011	
Medical Plan Prescriptions				
PPO Plan Prescription Benefit Manager and Specialty Pharmacy	CVS Caremark	www.caremark.com	1-866-748-0028 Fax: 1-866 443 1172 1-800-237-2767 (Specialty Rx)	(For Mail Order Prescriptions) P.O. Box 94467 Palatine, IL 60094-4467 (For Paper Claims) P.O. Box 52196 Phoenix, AZ 85072-2196
Blue Advantage HMO	Blue Cross and Blue Shield of Illinois	www.bcbsil.com	1-800-423-1973	(For Claim Submissions) 300 East Randolph Street Chicago, IL 60601-5099
Medical Plan Advisor	Telligen (formerly Encompass)	https://telligen.qualitrac.com	1-800-373-3727 Fax: 1-515-223-2990	1776 Westlakes Parkway West Des Moines, IA 50266-7771
PPO Plan				
Dental Plan	CompBenefits	www.compbenefits.com/custom/cityofchicago	1-800-837-2341	200 West Jackson, 9 th Floor Chicago, IL 60606-6910 (For Claim Processing) P.O. Box 14282 Lexington, KY 40512-4282
Dental HMO				
Dental PPO				
Vision Care Benefits	Davis Vision	www.davisvision.com	1-800-999-5431 1-877-393-8844	159 Express Street Plainview, NY 11803-9526
PPO Plan Blue Advantage HMO				

IMPORTANT WEB SITES, TELEPHONE NUMBERS, AND ADDRESSES

Flexible Spending Account	PayFlex (FSA)	www.HealthHub.com	1-800-284-4885	Flex Dept. P.O. Box 3039 Omaha, NE 68103-3039
Wellness Program Administrator	Healthways Health Advisors	www.chicagoliveshealthy.com	1-866-556-7671	
Taking Control of Your Health Diabetes Management Program	TCOYH Program		1-888-944-9090	
Life Insurance Plans				
Term Life Insurance	Prudential Insurance Company of America www.prudential.com	www.prudential.com	1-800-778-3827	P.O. Box 13676 Philadelphia, PA. 19176 Attn: Rebecca Wanner
Universal Life Insurance	MetLife Underwritten by TexasLife	www.empben/CityofChicagoUL.com	1-800-638-6855	2650 Warrenville Rd, Suite 100 Downers Grove, IL 60515
Long Term Disability	Prudential Insurance Company of America	www.prudential.com	1-800-778-3827	P.O. Box 13676 Philadelphia, PA 19176 ATTN: Rebecca Wanner
Deferred Compensation	Nationwide Retirement Solutions	www.chicagodeferrredcomp.com	1-312-443-1975 1-877-677-3678	205 W. Randolph, Suite 1540 Chicago, IL 60606-1814
Transit Benefit	Wageworks	www.wageworks.com	1-877-924-3967	1100 Park Place San Mateo, CA 94403
Pension Funds				
Uniformed Firefighters	Firemen's Annuity and Benefit Fund of Chicago	www.fabf.org	1-312-726-5823	20 S. Clark, Room 1400 Chicago, IL 60603-1899
Sworn Police	Policemen's Annuity and Benefit Fund of Chicago	www.chipabf.org	1-312-744-3891	221 N. LaSalle, Suite 1626 Chicago, IL 60601-1206
Municipal Employees	Municipal Employees and Annuity and Benefit Fund of Chicago (M.E.A./B.F.C.)	www.meabf.org	1-312-236-4700	321 N. Clark St., Suite 700 Chicago, IL 60654-4767
Laborer Employees	Laborers and Retirement Board Employee Annuity Benefit Fund of Chicago	www.labfchicago.org	1-312-236-2065	321 N. Clark St., Suite 1300 Chicago, IL 60654-4767

VI. ELIGIBILITY, ENROLLMENT, AND TERMINATION OF COVERAGE

Note: This Section applies to participants in this Plan (the PPO Plan) and also to participants in the HMO Plan. Accordingly, there may be references to the HMO or to HMO/insurance law requirements that do not apply to this Plan.

A. Eligibility

You are eligible to participate in the City's medical plans if you are:

- A crossing guard hired prior to January 1, 2006;
- A full-time salaried Employee;
- A full-time Employee compensated at an hourly or daily rate;
- A part-time Employee regularly scheduled to work at least 84 hours a month, except library pages;
- A regularly scheduled part-time School Dentist or a City Council Investigator if earning at least a Grade 1, Step 1 Salary from Schedule B of the Salary Resolution issued, by the City's Department of Human Resources;
- An individual classified by the City as a foster grandparent and covered under this Plan on May 31, 1984.
- A seasonal Employee who has completed at least 365 days of service and is scheduled to work full-time 180 or more days in a Calendar Year.

You are **not** eligible to participate if you are:

- A sworn police officer below the rank of sergeant and represented by the Fraternal Order of Police (their benefits are described in a separate document);
- A crossing guard hired on or after January 1, 2006;
- A seasonal Employee scheduled to work less than 180 days in a Calendar Year;
- A seasonal Employee who has completed less than 365 days of service (unless otherwise specified in the applicable collective bargaining agreement);
- An individual hired for a temporary program;
- An emergency appointment Employee;
- An individual paid by voucher;
- A library page, an aldermanic aide, or a traffic aide;
- A part-time Employee regularly scheduled to work less than 84 hours a month;

- An Employee earning less than a Grade 1, Step 1 Salary from Schedule B of the Salary Resolution issued by the City's Department of Human Resources;
- An Employee who has received a lifetime award from the Illinois Workers' Compensation Commission;
- An independent contractor.

Dependents

Dependents that may be enrolled are an Employee's Spouse, Domestic Partner, Civil Union Spouse, and child(ren). Employees who enroll a Spouse, Domestic Partner, Civil Union Spouse, or child as a Dependent are responsible for notifying the Benefits Service Center of any change in circumstances, including death or termination of the relationship that would disqualify the Dependent from further benefits. Failure to provide this required notice may lead to suspension or termination of the Employee's or Dependent's health benefits. Further, the Employee must reimburse the City for any claims paid in error on behalf of the ineligible Dependent.

An Employee's Child is covered if:

- The child is:
 - under age 26, or
 - 26 or older, unmarried, mentally or physically disabled prior to reaching age 26, covered by the Plan as of the day before his/her 26th birthday and dependent upon the Employee for support and maintenance, for the duration of the incapacity, provided the coverage does not otherwise terminate for any other reason and all other eligibility requirements are met. Proof of mental or physical incapacity and support is needed annually.
- In addition, for an extra cost per child, you may enroll unmarried children who are between the ages of 26 and 30, if such child received a discharge (other than a dishonorable discharge) from the U. S. military as long as the child is an Illinois resident and is dependent on you for financial support.

"Children" means individuals who are the Employee's:

- Natural children;
- Stepchildren;
- Domestic Partner's children;
- Civil Union Spouse's children;
- Children placed in the Employee's home for adoption;

- Legally adopted children; and
- Children under legal guardianship for whom the Employee is a legal guardian pursuant to an order of a court or administrative tribunal with appropriate jurisdiction.

Any Dependent who is in the military service of any country is not eligible for benefits.

A Dependent who loses coverage due to loss of dependent eligibility through one of the City's medical, dental or vision plans, may within 60 days of the date coverage was lost, elect to continue coverage through PHSA COBRA.

The Employee or Dependent must contact the PHSA COBRA Administrator to receive PHSA COBRA information and an enrollment application. (Refer to the "When Coverage Ends" section of this booklet for more details.)

There may be tax consequences for receiving benefits with respect to Dependents. In particular, if benefits are provided to persons who do not qualify as dependents under the Internal Revenue Code, such benefits may be taxable to the Employee. The fair market value of the benefits will be imputed as income for tax reporting and withholding purposes. **Employees and their Dependents should consult a tax adviser to understand these consequences further.**

Parties to a Civil Union

If you enroll or are enrolled in the Plan, you may also enroll a Civil Union Spouse (same or opposite sex) for Plan benefits by calling the Benefits Service Center or visiting www.cityofchicagobenefits.org and providing the documents listed below to the Benefits Service Center within the related timeframes:

- Complete enrollment with the Benefits Service Center within 30 days of the ceremony or at the time of your enrollment or the annual open enrollment period if the Civil Union already is in effect at that time (contact the Benefit Management Office or your department's benefits liaison for a form),
- A certified civil union certificate (from any Illinois county clerk) within 60 days of the ceremony, AND
- *Statement of Dependence* (if you are claiming your same sex Civil Union Spouse as a tax-qualified dependent as defined by Section 152 of the Internal Revenue Code).

Coverage for the Civil Union Spouse will terminate and continuation coverage benefits under PHSA COBRA will not be available to Civil Union Spouses in the event of the death of the Employee or dissolution of the Civil Union.

Domestic Partners

The City has extended health benefits to same sex Domestic Partners of Employees enrolled in the Plan.

Your Domestic Partner is eligible for coverage at the same time you are, if you submit the required documents to the Benefits Service Center.

Proof of domestic partnership is required. To determine if your Domestic Partner qualifies for enrollment, the following eligibility requirements must be met:

- First you, the Employee, must be enrolled in the PPO Plan or an HMO offered by the City.
- Then, you must obtain a *Certificate of Partnership* from the Department of Human Resources. To obtain a certificate you must submit a completed *Affidavit of Domestic Partnership* and meet the eligibility requirements for a Domestic Partner.

The Department of Human Resources will review your affidavit to determine if you meet the minimum eligibility requirements listed below:

You may enroll your Domestic Partner if:

- You and your Domestic Partner are each other's sole Domestic Partner, responsible for each other's common welfare; and
- Neither you nor your Domestic Partner are married or in a Civil Union with someone else (if you or your partner were previously married or in a Civil Union, proof of dissolution is required), and
- You and your Domestic Partner are not related by blood closer than would bar marriage in the State of Illinois, and
- You and your Domestic Partner are at least 18 years of age, are the same sex, and reside at the same residence, and
- At least two of the following four conditions must apply:
 1. You and your Domestic Partner have been residing together for at least twelve (12) months prior to filing the *Affidavit of Domestic Partnership*.
 2. You and your Domestic Partner have common or joint ownership of a residence.
 3. You and your Domestic Partner have at least two of the following arrangements:
 - a. Joint ownership of a motor vehicle;
 - b. A joint credit account;
 - c. A joint checking account; or

d. A lease for residence identifying both you and your partner as tenants.

4. You declare your Domestic Partner as a primary beneficiary in your will.

If the Department of Human Resources issues you a *Certificate of Partnership*, you must complete a health coverage enrollment by:

1. Submitting a *Certificate of Partnership* within 60 days of certification; and
2. Submitting a *Statement of Dependence* (if you are claiming your partner as a dependent as defined by Section 152 of the Internal Revenue Code).

To enroll your Domestic Partner, you must call the Benefits Service Center at 877-299-5111 or visit the website at www.cityofchicagobenefits.org within 30 days of the date of certification and submit the *Certificate of Partnership* to the Benefits Service Center within 60 days of certification. If you submit all the required documentation within the stated timelines, coverage will be effective as of the date of certification by the Department of Human Resources.

If you enroll after 30 days or you submit the *Certificate of Partnership* after 60 days, coverage will not be effective until the next January 1st.

Following the termination of a domestic partnership, a minimum of twelve (12) months must elapse before a new Domestic Partner may be designated. However, continuation benefits that might otherwise be available to former Spouses, such as PHSA COBRA benefits, are not available to Domestic Partners.

The decision of the City Benefits Manager on termination of Domestic Partner eligibility may be reviewed only by the Benefits Committee.

The premium deduction for your Domestic Partner or same sex Civil Union Spouse is taken after tax unless a Statement of Dependence has been submitted. There may be tax consequences for the receipt of Domestic Partner or same sex Civil Union Spouse benefits; Employees and their Domestic Partners or Civil Union Spouse should consult a tax adviser to understand these consequences.

B. Enrolling

To enroll for health benefit coverage, each Employee who meets eligibility requirements must enroll on line at www.cityofchicagobenefits.org or by calling the Benefits Service Center at 877-299-5111 within 30 days of his or her hire date, reinstatement, or Family Status Change. The City sponsors an Internal Revenue Code Section 125 Cafeteria Plan that allows you to pay for your share of coverage on a pre-tax basis.

Enrollment must be completed within 30 days of a Family Status Change in order to add yourself and/or an eligible Spouse and/or eligible Dependents. Family Status Changes for purposes of adding new Dependents include marriage, creation of a civil union, creation of a domestic partnership, birth or adoption of a child, and the loss of other health coverage

maintained by you and/or an eligible Spouse due to a loss of eligibility for such other coverage (including the exhaustion of COBRA coverage).

If you enroll more than 30 days after your hire date, reinstatement, loss of other coverage or Family Status Change, no coverage will be available. The next opportunity to enroll for Plan coverage in that case will be the next annual open enrollment period.

You may either complete enrollment online or call the Benefits Service Center at 877-299-5111. To complete the online enrollment, go to www.cityofchicagobenefits.org and follow these steps:

- Register as a user at www.cityofchicagobenefits.org;
- Log in; and
- Click the link in the upper left corner titled “Select Your Benefits” in order to begin the enrollment process for you and your Dependents.

Please keep in mind that the initial enrollment process and the documentation to establish eligibility are separate phases - each has a different due date, and both must be completed on time.

If you or your Dependent experience (1) a loss of eligibility for Medicaid or a state children’s health insurance program, or (2) become eligible to participate in a premium assistance program under Medicaid or a state children’s health insurance program, you and/or your Dependent will be entitled to receive coverage under the Plan. You must notify the Benefits Service Center within 60 days of either event described in this paragraph in order to be enrolled in the Plan. Enrollment will begin retroactive to the date of such event.

Please note that all newly hired Employees are eligible to participate only in the PPO plan for the first 18 months of their employment, not the HMO. Employees may enroll in the HMO effective as of the January 1st next following the date that is 18 months after their date of hire. An election to switch must be made during the open enrollment period immediately preceding that January 1st.

Proof of Dependency for Spouses and Children

You must enroll a Dependent within 30 days of the acquisition of the Dependent. You then must provide one or more of the following documents as proof of dependency within 60 days of the date your coverage is effective. To enroll a Dependent for coverage, the Employee is required to provide proof of Dependent status, such as, but not limited to the following (as applicable and determined by the City):

- Certified marriage certificate;
- Certified birth certificate for each child you claim as a Dependent. (The birth certificate must contain the names of the child and the Employee, Employee’s Spouse, or Civil Union Spouse or Domestic Partner, parent or parents.) For newborns only, you will be afforded up to 180 days to provide a birth certificate;

- Adoption papers for legally adopted children once you have obtained legal custody and have brought the child home. You will also need to submit a certified birth certificate and certified adoption papers within 60 days of the effective date of coverage. Please have foreign document(s) translated prior to submission to avoid a delay in processing.
- An order regarding legal guardianship or placement for adoption;
- Court orders if you are required to provide medical coverage for other children; or
- Proof of mental or physical incapacity and support for a disabled child on a form provided each year by the Benefits Service Center if incapacity is the basis for continued eligibility.

If any such documents are required as determined by the City in its sole discretion, all certificates, court orders, and divorce decrees must be certified. Non-certified documents or copies of certified documents will not be accepted. The certified documents will be returned so long as a self-addressed envelope, with sufficient postage, is provided to the Benefits Service Center along with the documents.

If you submit the required proof of dependency within 60 days of the date your coverage first begins, coverage for your Dependents will begin when your coverage begins. If you do not submit proof within 60 days, you will not be able to add your Dependents until the next open enrollment period for the following January 1 (unless you acquire a new Dependent through marriage, civil union, birth, or adoption).

For more information or for those who may have difficulty providing proof of dependency, contact the Benefits Service Center.

C. Coverage Under More than One Plan - No Dual Coverage

You may be covered under the Plan as either an Employee or as a Dependent; you may not be covered as both. A Dependent can only be covered by one City Employee. If you have a child who is a full-time City Employee, he or she must be covered as an Employee, not as a Dependent under your coverage.

If you are married or in a civil union or domestic partnership to another City Employee with who is participating as an Employee in a medical Plan offered by the City, you may elect to:

- Be covered as an Employee and pay the required premium. For example, your Spouse may want HMO coverage and you may not want HMO coverage. If you and your Spouse maintain separate coverage, you can each select a plan;
- Cover your Spouse, Civil Union Spouse, or Domestic Partner as your Dependent and the premium you pay will be based on your salary; or
- Be covered as a Dependent and your Spouse, Civil Union Spouse, or Domestic Partner will pay premiums based on his or her salary.

D. When Coverage Begins

Coverage for You and Your Dependents

You must enroll in the Plan before your coverage is effective. Your coverage will be effective on the first day of the month after your hire date if:

- You enroll within 30 days of your hire date; and
- The City begins the required payroll deduction.

For example, if you are hired on March 5, your coverage will begin on April 1 if you enroll by April 4 (30 days from March 5) and your payroll deductions begin. Your Dependents are eligible for coverage at the same time you are, if you submit the required documents to the Benefits Service Center.

Enrollment may be done on line at www.cityofchicagobenefits.org, or by calling 877-299-5111. Required documentation for Dependents includes proof of dependency (as described on page 18).

You must complete enrollment if you want coverage for your Dependents. Your enrollment must be completed before the effective date of your coverage, but not later than 30 days from your hire date. If you wait more than 30 days to apply for dependent coverage, you will not be able to add your Dependents until the next open enrollment period for coverage beginning the following January 1.

To enroll on-line, follow these steps:

- Register as a user at www.cityofchicagobenefits.org;
- Log in;
- Click the link in the upper left corner titled “Select Your Benefits” in order to begin the enrollment process for you and your Dependents.

Newborn Coverage: Two Step Process

Notwithstanding anything contained herein to the contrary, newborns are eligible for coverage as of the date of birth, provided that the Employee is enrolled or enrolls for coverage effective as of that date and completes the following steps:

Step One: The Employee must complete enrollment on-line at www.cityofchicagobenefits.org or by calling the Benefits Service Center at 877-299-5111 for coverage for the newborn within 30 days of the date of birth of the newborn.

Step Two: The Employee must also submit a certified birth certificate to the Benefits Service Center within 180 days of the child's date of birth.

If the Employee completes the enrollment for coverage within 30 days and submits the certified birth certificate within 180 days, coverage is retroactive to the date of birth. If the on-line or telephone application for coverage is not made within 30 days or the certified birth certificate is not received within the required 180 days, coverage will be effective as of the first day of the next Plan Year, provided the enrollment is completed and the birth certificate is received by that date.

The enrollment and the certified birth certificate to establish eligibility can be done separately as each has a different due date. However, each form must be submitted on time.

You will not need the newborn's social security number to enroll newborns for coverage, but you will be required to provide the number at a later date.

Alternative Coverage

If you applied for coverage for yourself or an otherwise eligible Dependent and were denied coverage because of failure to meet the enrollment or documentation deadlines of the Plan, you will be notified of the denial by the Benefits Service Center. The notice will inform you of the availability of Alternative Coverage. Alternative Coverage is identical to regular coverage except that you will be required to pay a higher premium. If you wish to enroll in the Alternative Coverage program you must complete an *Alternative Coverage Enrollment Form* (available from the Benefits Service Center) and submit it to the Benefits Service Center within 30 days of the date of the denial notice. If you submit the *Alternative Coverage Enrollment Form* after 30 days from the date of notice, you may not enroll in the Alternative Coverage program.

Alternative Coverage will be offered to an individual who:

- Would otherwise be eligible under the Plan,
- Has submitted all necessary documents,
- Has been denied coverage under the Plan because he or she failed to comply with the Plan's enrollment requirements,
- First became eligible for coverage subsequent to the close of the most recent open enrollment period, and
- Agrees to pay the required premium.

Persons who are entitled to coverage as the Spouse, Civil Union Spouse, or Domestic Partner of an eligible Employee and who have been denied coverage under the Plan because the Employee failed to comply with the Plan's enrollment requirements will not be eligible for Alternative Coverage if such person is currently covered by other medical coverage.

You must indicate on the *Alternative Coverage Enrollment Form* the type of coverage you are requesting. The two types of coverage available are:

- **Retroactive coverage.** If you elect retroactive coverage, coverage will be effective as of the date you and or your dependent(s) would have been eligible for

coverage if you had completed enrollment in a timely manner. You will be required to pay the Alternative Coverage premium from the date you would have been eligible. Premium payments for Alternative Coverage are due at the time of application for the period of retroactive coverage. Premiums shall be due thereafter no later than the first day of the month for which the coverage is effective.

- **Prospective coverage.** If you elect prospective coverage, coverage will be effective on the first day of the month following the month in which you submit the required premium. Premiums are due thereafter no later than the first day of the month for which coverage is effective.

In any event, Alternative Coverage will end the next December 31st or for those who missed open enrollment, the December 31st of the following year, at which time those persons receiving Alternative Coverage will be eligible for and enrolled in regular coverage under the Plan during the applicable open enrollment period.

Examples of coverage:

Example 1 - You have a new baby on June 1, 2010 and apply for coverage for the baby on August 10, 2010. You would receive a denial notice from the Benefits Service Center because you failed to apply for coverage within 30 days of the Family Status Change, which in this case is the birth of your child. You would have 30 days from the date of the denial notice to apply for Alternative Coverage for your newborn. If you apply for Retroactive coverage, coverage is effective from the date of birth of the child and you would be required to pay premiums from June 1, 2010, until December 31, 2010.

Example 2 - You are married on February 14, 2010, and apply for coverage for your spouse on May 1, 2010. You would receive a denial notice from the Benefits Service Center because you failed to apply within 30 days of the Family Status Change, your marriage. You would have 30 days from the date of the denial notice to apply for Alternative Coverage for your spouse. If you complete enrollment for Prospective coverage on May 15, 2010, coverage will be effective June 1, 2010 if you pay the required premium. You would pay premiums from June 1, 2010, until December 31, 2010.

Example 3 - You are hired and fail to apply for coverage within 30 days of your date of hire. Several months later you complete enrollment and the required documentation. If an open enrollment period has not occurred between your hire date and the time you apply, you may apply for Alternative Coverage.

However, if an open enrollment period occurred you would not be eligible for Alternative Coverage because you had the opportunity to enroll during the open enrollment period. You will be eligible to enroll during the next open enrollment period for the following January 1st.

Alternative Coverage for Dependents will be provided under the plan in which the Employee is enrolled. All relevant plan terms will apply. Covered expenses will be

included in any calculation of deductibles and out-of-pocket expenses in accordance with the applicable plan.

Premiums are subject to change each January 1st

Premiums for Alternative Coverage must be paid directly to the Benefits Service Center by check or money order on an after-tax basis. No deduction can be taken from an Employee's check. In the event an Employee submits a check that is returned from the bank because of non-sufficient funds (NSF), the Alternative Coverage shall be terminated as of the last day of the month for which premium payments were received.

Coverage can be terminated for failure to make required payments in a timely manner. No one whose Alternative Coverage is terminated can be enrolled until the Plan's open enrollment period for the following January 1st.

E. Choose A Plan Once a Year

Each year, you will have the opportunity to enroll or change the level of your coverage during the open enrollment period.

Limited Changes During The Year

You will be able to change your level of coverage during the year only if you have a Family Status Change, such as:

- Your marriage or divorce,
- Formation or dissolution of a civil union or Domestic Partnership,
- Birth or adoption or placement for adoption of a child,
- Death of an eligible Dependent,
- A covered Dependent child reaching the age limit, or
- A loss of health insurance maintained by you and/or an eligible spouse due to a loss of eligibility for such other coverage (including the exhaustion of COBRA coverage).

You must notify the Benefits Service Center of a Family Status Change and submit documentation to support the change with your request. This means you cannot drop or add Dependents during the year unless you:

- Experience a Family Status Change as described above, and
- Notify the Benefits Service Center within 30 days of the change.

Payroll deductions cannot be changed unless the Benefits Service Center is notified within 30 days of the Family Status Change. The change in deduction must be consistent with the Family Status Change.

Enrollment. You must notify the Benefits Service Center within 30 days of a Family Status Change. In the case of Family Status Change that justifies enrollment in the Plan, coverage will be effective on the date of the Family Status Change, assuming you also submit proof of the change in the required time period (see below). If your enrollment form indicating your request for a change in coverage is not submitted within 30 days, you will not be able to make the change until the next open enrollment period for the following January 1st.

Proof of Change. You must also submit documentation to support the change in coverage. This documentation must be submitted within 60 days of an eligible Family Status Change. If you don't submit the required documents within 60 days, you will not be able to make the change until the next open enrollment period for the following January 1st.

Examples of Mid-Year Changes

Any mid-year change must be consistent with your status change.

Example 1 - If you have coverage for yourself and then get married, you'll be able to add medical coverage for your Spouse.

Example 2 - If you adopt or give birth to a child, you can add your new child to your coverage.

Example 3 - If your Spouse loses medical coverage because he or she is laid off from his or her job, you can add your spouse to your medical coverage.

Example 4 - You currently cover your Dependents under this Plan and your Spouse decides to elect coverage at work during his or her employer's open enrollment period. You can drop yourself, your Spouse and/or your Dependent children, and change your level of coverage. This change must be requested within 30 days of your new coverage.

Note: If you are not currently enrolled in the Plan, you will have an opportunity to enroll yourself (along with your new Spouse or Dependent) when you gain a dependent through marriage, birth, adoption or placement for adoption.

Here are some examples of changes not considered Family Status Changes:

Example 1 - You get married but you don't notify the Benefits Service Center for six months. Since you did not request coverage for your spouse within 30 days of your marriage, you will have to wait until the next open enrollment period to add this coverage. (However, Alternative Coverage may be available; see page 21.)

Example 2 - You decide that you no longer want coverage for your children. Since this is not a Family Status Change, you'll have to wait until the next open enrollment period to drop coverage for your children.

F. When Coverage Ends

Benefits will no longer be available for the Employee and Dependents, and coverage will end:

- After the fifth consecutive working day that the Employee is absent without pay, (however, if the Employee is an hourly Employee and on a medical leave of absence in the Labor and Trades Coalition Bargaining Group and makes the required Employee contribution, coverage will continue through the end of the current month and also continues for one additional month);
- On the 31st day of a suspension lasting longer than 30 days;
- If the Plan is discontinued;
- When an Employee is no longer part of an Employee group covered by this Plan;
- The date the Employee ceases active employment with the City for any reason other than disability or death;
- If the Employee takes an unpaid leave of absence, except as otherwise required by the Family Medical Leave Act;
- On the date it is determined that the Employee knowingly presented bills for services that were not received or submits bills for a Dependent who is not eligible;
- When the Employee fails to make required contributions;
- If the Employee receives a lifetime award from the Illinois Workers' Compensation Commission;
- When any act of fraud or material misrepresentation is committed by the Employee or Dependent (including a failure to notify the Plan of a loss of dependent status such as divorce).
- When the Employee dies.

Additionally, benefits for Dependents will no longer be available and coverage will end in the following circumstances:

- Death of the Dependent;
- Divorce (Spouse) or dissolution (Civil Union Spouse or Domestic Partner);
- Dependent child exceeds the Plan's age limit; or
- Other change in status that would cause the Dependent to no longer to qualify as a Spouse, Civil Union Spouse, Domestic Partner, or child as defined in the Plan.

You must drop ineligible Dependents such as divorced Spouses or you will be billed for the full cost of that person's coverage. (In the case of the PPO, this means that you could be billed for any claims paid after loss of eligibility. In the case of the HMO, this means that you could be billed for the premium paid by the City after loss of eligibility.) (See the When

Coverage Ends Section, page 24.) Additionally, you may be subject to other adverse consequences including loss of coverage, discipline, and termination of employment.

Retroactive Rescission (Termination) of Coverage

The Plan generally will not terminate your medical coverage on a retroactive basis. However, the Plan will terminate coverage retroactively of Employees and their Dependents if benefits were provided due to fraud or intentional misrepresentation of material fact. Additionally, the Plan may terminate coverage retroactively due to failure to pay a premium. You will receive 30 days advance notice if your coverage will be terminated retroactively.

Continuing Coverage as an Inactive Employee

If you are covered by the Plan and are a full-time law enforcement officer or firefighter who suffers a catastrophic injury in the line of duty, you may receive continuation coverage at no cost for yourself and your Dependents as set forth in the Public Safety Employee Benefits Act (820 ILCS 320/10). (For more information about Dependent continuation in this situation, see “Dependent Coverage” below.)

Additionally, the Benefits Service Center administers a direct pay program so that certain other inactive (those not Actively at Work) Employees can continue benefits in one of the following circumstances. You must contact the Benefits Service Center within 30 days of the occurrence of any of the following circumstances or as otherwise required by the Family and Medical Leave Act of 1993 and complete any required steps:

- If you are on Ordinary Disability and receiving pension plan ordinary disability benefits, you may continue medical coverage by paying the full cost of coverage;
- If you are on an approved unpaid personal or medical leave, you may continue coverage for up to six months by paying the full monthly cost of coverage (which includes both the amount that you normally pay and the cost normally borne by the City);
- If you are on an approved unpaid personal leave of absence of less than 30 days, you may continue coverage by paying the monthly cost of coverage on a prorated basis (prorated according to the number of days for which you are absent);
- If you are receiving paid sick leave or extended sick leave benefits, you may continue coverage for the length of the benefits if you make the required Employee contributions (or payroll deductions);
- If you are receiving Duty Disability benefits from an employer pension plan (other than the Policemen’s Annuity and Benefit Fund of Chicago or Firemen’s Annuity and Benefit Fund of Chicago), you may continue coverage for the length of time that you receive the workers' compensation benefits, if you make the required Employee contributions;
- If you are receiving Duty Disability or Occupational Disability benefits from the Policemen’s Annuity and Benefit Fund of Chicago or Firemen’s Annuity and

Benefit Fund of Chicago, you may continue coverage for the length of the benefits at no cost;

- If you are receiving both Duty Disability benefits from an employer pension plan and a lifetime award from the Illinois Workers' Compensation Commission, you may continue coverage for yourself according to PHSA COBRA guidelines for up to 18 months following the date of the award by paying the full monthly premium (which includes both the amount that you normally pay and the cost normally borne by the City) plus the 2% administrative fee;
- If you are receiving both Duty Disability benefits from an employer pension plan and a lifetime award from the Illinois Workers' Compensation Commission, you may continue medical coverage for your eligible dependents by paying the required monthly contribution for the length of the disability or until the earlier of the following:
 - Your dependent child reaches the end of eligibility,
 - You retire (meaning that you are no longer receiving Duty Disability benefits and instead are receiving pension benefits from the applicable pension fund) or reach age 65, or
 - You die.
- If you are receiving workers' compensation benefits, other than a lifetime award from the Illinois Workers' Compensation Commission, the Employee may continue coverage for himself/herself and eligible Dependents for the length of the benefits if the Employee makes the required Employee contributions;
- If you are a school crossing guard hired on or before January 1, 2006, coverage will be continued during the summer vacation period;
- If you are a school crossing guard hired on or before January 1, 2006 and on an approved medical leave of absence, your medical coverage may continue for up to five months each year at no cost to you;
- If you are suspended for more than 30 days, you may continue coverage after the 30th day by paying the full cost of coverage for the term of the suspension;
- If you are laid off and are a member represented by a labor and trades bargaining unit or the AFSCME bargaining unit and make the required Employee contributions, the City will pay its share of the cost for coverage for the month in which you are laid off and for four months following layoff;
- If an Employee is Totally Disabled at the time coverage would otherwise end as set forth in Section F above, benefits will continue at no cost for expenses incurred related to the Injury or Illness that caused such Total Disability as follows:

- With respect to Hospital benefits, three months.
- With respect to non-Hospital benefits, (i) for a period that is the same length of time that the Employee was covered by the Plan prior to incurring the Total Disability if less than 12 months; (ii) for 12 months if the Employee was covered by the Plan at least 12 months prior to incurring the Total Disability; or (iii) until the date the Employee is covered under another plan that will pay expenses related to the Total Disability, if less than the stated time frames in (i) or (ii).

Dependent Coverage

Coverage for Dependents ends at the same time the Employee's coverage ends (or earlier if the Dependent no longer qualifies for coverage or commits an act of fraud or material misrepresentation). However, the Dependent can continue medical benefits as follows:

- If the Employee is a full-time law enforcement officer, or firefighter and is killed in the line of duty or suffers a catastrophic injury, Dependent coverage will continue at no cost until the earlier of the date the Spouse reaches age 65 or remarries with respect to spousal coverage and, with respect to Dependent children, until the Dependent children otherwise no longer meet the requirements to be considered eligible Dependents.
- If any Employee dies under circumstances other than those described in the first bullet point above, Dependent coverage will continue at no cost for the lesser of 90 days or until the Dependent child(ren) otherwise are no longer eligible Dependents. Your eligible Dependents must be covered under the Plan at the time of death to be eligible for this free coverage.
- If the Dependent is Totally Disabled at the time coverage would otherwise end as set forth in this Section F, benefits will continue, at no cost for expenses incurred related to the Injury or Illness that caused the continuing Total Disability as follows:
 - With respect to Hospital benefits, for three months.
 - With respect to non-Hospital benefits, (i) for a period that is the same length of time that the Dependent was covered by the Plan prior to incurring the Total Disability if less than 12 months,, (ii) for 12 months if he or she was covered by the Plan at least 12 months prior to incurring the Total Disability, or (iii) until the date the Dependent is covered under another plan that will pay expenses related to the disability if less than the time frames set forth in (i) and (ii).

Certificate of Coverage

The federal Health Insurance Portability and Accountability Act (HIPAA) requires the Plan to provide a certificate of creditable coverage to Participants at the time coverage is cancelled. The certificate provides evidence of prior creditable coverage to the Participant in case the Participant becomes covered under a new group plan that excludes coverage for pre-existing medical conditions the Participant may have. The certificate will provide information to a new insurer or plan that the new insurer or plan may use to determine whether and for how long it can exclude covering services for a pre-existing condition. (As a general matter, the pre-existing condition exclusion period will be offset by each month of prior creditable coverage that you have.)

PHSA COBRA Coverage

PHSA COBRA coverage may be available as described on page 30 following the direct pay coverage extensions described in this Section F.

G. Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) is a federal law that allows eligible Employees to take unpaid leave under certain circumstances. Employees on FMLA leave are entitled to the same health coverage from the City during the leave under the same conditions as if they were working.

If on an unpaid FMLA leave, the Employee can continue coverage for the length of the FMLA leave by making the required Employee contributions. An application for continuing coverage and a billing statement will be sent after the Benefits Service Center has received approved FMLA paperwork. Failure to make the required contributions will result in termination of coverage.

If an Employee's FMLA leave has been exhausted and he/she has not yet returned to work, the Employee may be eligible to continue coverage through the direct pay program as set forth in Section F or through PHSA COBRA. Contact the Benefits Service Center about continuing coverage after an FMLA leave.

H. Military Leave/USERRA

If an Employee takes a leave of absence to enter military service under USERRA, federal law requires that the Employee be offered the opportunity to continue Plan coverage at his own expense for up to 24 months.

I. Reinstating Coverage

When returning to work after an approved leave (e.g., medical, FMLA, military, personal), an Employee must call the Benefits Service Center at 877-299-5111 to reinstate or continue coverage if coverage was discontinued during the leave or to continue coverage after the leave ends. You also must notify the Benefits Service Center of any family members in need of reinstatement or continuation.

Separate enrollment and certified documents are not required again to reinstate coverage for Dependents.

If the Benefits Service Center is not notified within 30 days following the Employee's return to work, there will be no health coverage for the Employee or previously covered family members. The next opportunity to enroll will be the next annual open enrollment period.

J. Continuation of Coverage after Termination - Public Health Service Act PHSa (COBRA)

In 1985, Congress enacted continuation health coverage requirements in Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA amended the Public Health Services Act (PHSA) to protect certain Employees and their dependents when they lose their coverage under a group health plan for certain reasons. In accordance with and subject to the PHSA, when coverage under this Plan ends, medical benefits may be continued, depending on the circumstances, at the Participant's own expense for a temporary period. To be eligible, a qualifying event causing the loss of coverage must take place.

The following chart shows who is eligible to continue under the Plan (i.e., who is considered a "qualified beneficiary" under the PHSA) and how long coverage may continue.

Additional information also is available on line at www.cityofchicago/benefits.

Qualifying Event Ending Coverage	Who May Continue (Qualified Beneficiaries)	Longest Period of Continuation
Employee termination or layoff*	Employee, Spouse, Dependent Children	18 months**
Employee's hours reduced	Employee, Spouse, Dependent Children	18 months**
Employee dies	Spouse, Dependent	36 months
Employee's coverage ends because Employee chooses Medicare as primary coverage	Spouse, Dependent Children	36 months
Employee's divorce	Spouse, Dependent Children	36 months
Dependent no longer eligible (due to reaching limiting age)	Dependent Children	36 months

*PHSA COBRA Continuation Coverage is not available if the Employee is discharged for gross misconduct.

**If the Employee or a Dependent is disabled at the time of the qualifying event, or within 60 days following the qualifying event, coverage may be continued for up to a total of 29 months.

A child that is born to or placed for adoption with a former employee during a period of PHSA COBRA coverage may be added to coverage as a qualified beneficiary by giving notice to the Plan Administrator within 30 days of the adoption or placement.

Domestic Partner and Civil Union Spouses are not entitled to PHSA COBRA continuation coverage under this Plan.

When can PHSA COBRA Continuation Coverage be Extended?

There are two ways in which the 18-month period of PHSA COBRA continuation coverage resulting from a termination of employment or a reduction of hours may be extended, as explained below.

Disability extension of 18-month period of continuation coverage

If a qualified beneficiary is determined by the Social Security Administration (SSA) to be disabled and you notify the PHSA COBRA Administrator within 60 days of the date of the determination and prior to the expiration of the initial 18-month period, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of PHSA COBRA continuation coverage, for a maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving PHSA COBRA continuation coverage because of a covered Employee's termination or reduction of hours. The disability must have started at some time before the 61st day after the covered Employee's termination or reduction of hours and must last at least until the end of the period of PHSA COBRA continuation coverage that would be available without the disability extension (generally 18 months, as described above). A final determination of disability status must be made by the SSA prior to the end of the 18-month PHSA COBRA continuation coverage period.

Second qualifying event extension of PHSA COBRA continuation coverage

If your family experiences another qualifying event while receiving PHSA COBRA continuation coverage due to the covered Employee's termination of employment or reduction of hours (including PHSA COBRA continuation coverage during a disability extension period as described above), the Spouse and Dependent children receiving PHSA COBRA continuation coverage can get up to 18 additional months of PHSA COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse and any Dependent children receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child.

With respect to an employee who becomes entitled to Medicare while still employed and then retires, the maximum PHSA COBRA period after such retirement (or termination) for qualified beneficiaries other than the Employee, will be the *longer* of (i) 18 months from the date of employment termination; or (ii) 36 months from the date the Employee became entitled to Medicare.

Benefits Provided

The benefits provided will be the same as those provided to Employees and Dependents covered under the Plan. If the Plan changes, benefits provided under continuation of coverage will also change.

Cost

If the Participant chooses to continue coverage after termination, he or she will have to pay the full cost of coverage plus a 2% administrative fee permitted under applicable law. The Employee and/or Dependent will be notified of the cost. This cost may change once a year.

Notification

The Participant must notify the PHSA COBRA Administrator in writing within 60 days after certain qualifying events occur (or the date of loss of coverage, if later) to be eligible for continuation coverage. Such qualifying events include a loss of Dependent child status, divorce, or legal separation.

After the PHSA COBRA Administrator has been notified that a qualifying event has occurred, the PHSA COBRA Administrator will notify the Participant about the options to continue coverage. If the Participant fails to notify the PHSA COBRA Administrator within the required time, the Plan may not continue coverage.

To continue coverage, the Participant must submit his or her election in writing to the Benefits Service Center. To preserve his or her right to elect continuation coverage, the Participant (or a representative acting on his or her behalf) must complete and return the election form provided by the PHSA COBRA Administrator as soon as possible, but no later than 60 days after the later of (i) the date of the notice from the PHSA COBRA Administrator, or (ii) the date coverage otherwise would end. The completed election form must be returned to the PHSA COBRA Administrator.

If a Participant elects to continue coverage, the first payment for continuation coverage must be submitted within 45 days of the date of election to continue coverage. The first payment must include payment for the period from the date that the Participant lost (or otherwise would have lost) coverage until the date of the election, and each regularly scheduled monthly payment that became due during the period between the election and the first payment.

It is important to keep the City and PHSA COBRA Administrator updated of your current address to ensure that you receive proper notifications.

When Coverage Ends

The City's continuation coverage will stop before the maximum continuation period shown in the chart if one of the following events occurs:

- Failure to pay the full cost for coverage on or before the date specified;
- An act of fraud or a material misrepresentation has occurred;
- The covered individual becomes covered by Medicare after an election of PHSA COBRA coverage;

- Coverage is started under another group health plan, unless coverage is delayed or denied because of a pre-existing condition after an election of PHSA COBRA coverage; or
- The City discontinues medical coverage offered to Employees.

Converting Your Medical Coverage

Although not required by law, conversion to an individual policy after group coverage under this Plan ends may be available. When your coverage ends or when your continuation coverage ends, you may apply to the Claims Administrator for an individual policy within 31 days after coverage ends. The benefits and provisions of the individual policy may differ from the City's plan. When a Dependent's coverage ends, he or she may also be able to convert to an individual policy within 31 days after coverage ends. It is your responsibility to obtain forms from the Claims Administrator as identified earlier in the Important Contact Information Section and apply for coverage.

Conversion is also available to Dependents if coverage ends due to:

- The death of the Employee. The surviving spouse may be eligible to convert coverage for himself or herself and any children who are covered by the Plan. A Dependent child may also convert coverage because of marriage or upon his or her attaining the limiting age of coverage under this Plan; or
- An Employee's divorce or annulment of marriage. The divorced spouse or former spouse then covered by the Plan may be eligible to convert coverage for himself or herself. You will need to contact the Claims Administrator to request this coverage.

K. Fraudulent Coverage/Non-Transfer/Failure to Notify

Any kind of fraud on the Plan may result in adverse consequences to an Employee and his Dependents. Examples of fraud include:

- Failure to notify the City's Benefit Management Office of an event that would cause the coverage of a Participant to end (such as divorce).
- Misrepresentation by the Employee or his or her Dependent regarding the initial eligibility of himself or a Dependent in the first place. The Employee will be required to pay for any claims and all administrative or other fees incurred on behalf of, or related to, the ineligible person from the date the person was not eligible for coverage through the effective date of termination of coverage.
- An attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage or benefits. (This means that you cannot give your plan ID card to someone else to use.) Any such assignment or transfer of coverage is null and void.

The City may, at its option, pursue collection or elect to offset any amounts mistakenly paid or fees incurred as a result against the future benefits of the Employee and any remaining covered Dependents. Moreover, the City at its option may terminate the coverage of the Employee and any remaining covered Dependents based on the failure to notify the City of an event that would cause the coverage of a Participant to be terminated, misrepresentations or improper assignment or transfer of coverage as described above, or for failure to cooperate with the recovery of funds. Additionally, the City may discipline the Employee (up to and including termination of employment). Lastly, if you fail to timely notify the City of a PHSA COBRA qualifying event, you or your Dependent (as applicable) will not be entitled to PHSA COBRA continuation coverage.

VII. MEDICAL ADVISOR REVIEW PROGRAM

The chart on the next page summarizes the features of the Medical Advisor Review program. The program is explained in more detail in this section. Be sure to review the following pages for a full list of services and supplies that must be reviewed by the Medical Advisor. Remember, to receive maximum benefits for certain treatments, call the Medical Advisor at the number located in Section V., Important Contact Information.

You will pay all expenses for any supplies, services or hospital stays that are determined to be not Medically Necessary.

If You and/or Your Covered Dependents	When to Contact the Medical Advisor	If you Don't Contact the Medical Advisor*
Require long-distance ambulance (or other) transportation or ambulance transportation from one Hospital to another	Before being transported	You pay for transportation
Become pregnant	Before end of the first trimester	No penalty
Will be admitted to the Hospital or Skilled Nursing Facility for a non-emergency inpatient stay	At least 24 hours before you are admitted	You pay \$1,000 of covered expenses and all expenses determined to be not medically necessary
Will be admitted to the Hospital or Skilled Nursing Facility for an emergency inpatient stay	Within 2 business days of admission	You pay \$1,000 of covered expenses and all expenses determined to be not medically necessary
Receive outpatient mental health or substance abuse treatment	If you need more than 7 visits (in total from one or more providers), contact Medical Advisor before the 8th visit each year	Benefits will be paid for first 7 visits only each year
Need home health care	Before care begins	You pay all expenses
Require hospice care	Before care begins	You pay all expenses
Require skilled nursing home care	Before care begins	You pay all expenses

If You and/or Your Covered Dependents	When to Contact the Medical Advisor	If you Don't Contact the Medical Advisor*
Receive outpatient occupational or speech therapy	If you need more than 10 visits, contact the advisor before the 11th visit each year	Benefits will be paid for first 10 visits only each year
Obtain infertility services	Before obtaining services	No penalty, unless specific service otherwise requires Pre-Certification
Require an organ transplant	Before care begins	You pay all expenses
Require bariatric surgery	Before care begins	You pay all expenses
Need durable medical equipment	Before purchase if over \$500	You pay all expenses
Need MRI, CT or PET scan (Not applicable if administered on an Inpatient basis or while receiving Emergency Medical Care in the emergency room)	Before obtaining services	You pay all expenses if found not to be Medically Necessary
*Any extra amounts you have to pay if you don't contact the medical advisor will not count toward your deductible or out-of-pocket limit.		

The Medical Advisor Review Program is a key component of the Plan. It is designed to review certain medical care you receive to determine if it is Medically Necessary and appropriate, as defined by the Plan. Please review this section carefully; the review program is a valuable resource and can help you maximize your plan benefits. If you do not make the required notifications on a timely basis, you will pay more for certain health services.

To contact the Medical Advisor, use the contact information found in the Important Contact Information Section or on the City's benefits website at www.cityofchicago.org/benefits.

The Medical Advisor can:

- Certify Hospital confinements for you and your Dependents;
- Explain alternatives to Hospital Care;
- Facilitate the early discharge of a hospitalized Participant;
- Make recommendations about the Medical Necessity of treatments and services to the Claims Administrator; and

- Provide a disease/case management and high-risk pregnancy screening program, which is voluntary.

To make sure that certain treatments and Hospital stays are appropriate and eligible for maximum coverage you or someone acting on your behalf must contact the Medical Advisor. The following services require Medical Advisor review and/or Pre-Certification (prior to services being started):

- Hospital stays, including:
 - Non-emergency Hospital admissions;
 - Hospital admissions as a result of Emergency Medical Care;
 - Mental health or substance abuse admissions;
 - Maternity Hospital admissions; and
 - Skilled Nursing Facility admissions.
- Other services that require review:
 - Durable Medical Equipment over \$500;
 - Outpatient speech therapy or occupational therapy exceeding ten visits in a Calendar Year;
 - Home Health Care;
 - Hospice care;
 - Services at facilities and/or programs that are alternatives to inpatient Hospital Care for treatment of mental health and/or substance abuse conditions;
 - Ambulance Transportation from one Hospital to another Hospital equipped to provide special treatment;
 - CAT scans, MRI scans and PET scans (unless performed on an in-patient basis or as part of an emergency room visit);
 - Outpatient or Physician based mental health treatment after the first seven sessions in any Calendar Year;
 - Human organ transplants;
 - Infertility services, such as IVF;
 - Bariatric surgery (weight loss); and

- In-patient surgery.

If you do not contact the Medical Advisor before receiving the services listed above, the Plan will not pay for them. However, with respect to Hospital stays (including and Skilled Nursing Facility stays) only, you will be given the opportunity upon appeal to demonstrate that the stay was Medically Necessary. If you can do so, then the stay will be covered under the terms of the Plan, subject to the \$1,000 penalty described below.

Hospital and Skilled Nursing Facility Stays

All Hospital and Skilled Nursing Facility stays must be Certified by the Medical Advisor as follows:

- Non-emergency Hospital/Skilled Nursing Facility admissions: You or someone acting on your behalf must call the Medical Advisor at least 24 hours before being admitted to a Hospital as an Inpatient.
- Hospital admissions following Emergency Medical Care: You or someone acting on your behalf must call within two business days following an inpatient Hospital admission.

Failure to Contact the Medical Advisor

The final decision about your health care treatment is up to you and your Physician. However, if you do not call the Medical Advisor within the required timeframes, you will have to pay the first \$1,000 of covered hospital expenses. **This penalty amount will not count toward the Deductible or Out-of-Pocket Limit.** Additionally, your claim will be denied based on a failure to contact the Medical Advisor. However, if you appeal the denial, you will be given the opportunity to contact the Medical Advisor to obtain a review of Medical Necessity. If any Hospital or Skilled Nursing Facility days or services are determined by the Medical Advisor to be not Medically Necessary, the appeal will be denied and you will be responsible for all charges for those days. Thus, it is best if the Participant contacts the Medical Advisor as required to determine whether services are Medically Necessary.

Getting Certification for Hospital Stays

When calling the Medical Advisor, have this information ready;

- Employee's Unique Identification Number;
- The name and date of birth of the person who is hospitalized or will receive treatment;
- The Hospital's name;
- The reason for the Hospital admission;
- The scheduled admission date;

- The name, address, and telephone number of the admitting Physician; and
- The diagnosis, if available.

Getting Certification for Other Services

When calling the Medical Advisor, have this information ready:

- The name and date of birth of the person who will receive the treatment services;
- Employee's Unique Identification Number;
- The name, address and telephone number of the treating Physician;
- For MRI scans, CAT scans and PET scans, the date and the name of the imaging test being requested; and the diagnosis, if available or reason for the scan.

Disease Management Program

The Plan also recommends that the Medical Advisor be contacted for certification of treatment plans for the following chronic diseases:

- Cardiovascular Disease;
- Asthma;
- Diabetes; or
- Chronic Obstructive Pulmonary Disease (COPD).

Other programs may be added in the future. You will be notified in advance of any changes to the Disease Management Program.

Participants are required to call the Medical Advisor if they are being treated for cardiovascular disease, asthma, diabetes or chronic obstructive pulmonary disease as soon as reasonably feasible following the later of the date of your receipt of this document or diagnosis. The Medical Advisor will ask questions about medical history, medication history and a description of the attending Physician's treatment plan. The Participant will have the opportunity to ask questions and receive educational literature about the particular medical condition.

The Medical Advisor will assess the treatment plan to determine if it is consistent with the patient's current status, history, and generally accepted standards of medical practice. To the extent that the patient's treatment plan is not consistent, a Physician reviewer may contact the patient's attending Physician to gather additional information and discuss results of the review. If the attending Physician and the reviewing Physician cannot agree, the patient may be sent for an independent medical examination at the Plan's expense.

Depending on the level of the patient's compliance with the treatment plan, the patient may be contacted again in a specified period of time. Patients whom the reviewer determines are

non-compliant, or who have unacceptable treatment plans, will be monitored closely with more frequent follow-up reviews by the Medical Advisor.

If, in the judgment of the Medical Advisor, certain expenses not normally covered by the Plan would be cost-beneficial to the Plan, and if the patient continues to make required lifestyle changes, those expenses may be eligible for coverage. These expenses may include, but are not limited to, the following: counseling with a dietitian for either a diabetic or an obese person with complicating conditions; or a home nursing visit to provide training in use of medications for an asthmatic.

If you have diabetes, you may be eligible to participate in the Taking Control of Your Health (“TCOYH”) Diabetes Management Program. Under this program, you may qualify for free medications or reduced Copayments. For further information, please see the discussion regarding the program in Article XI Prescription Drug Coverage.

Case Management

In addition, the Plan provides a case management program to assist you in the event of a catastrophic Illness or Injury or certain complex medical cases to identify the most appropriate short and long-term treatments, such as:

- Multiple Hospital admissions;
- Complex treatment, such as treatments for cancer, acquired immune deficiency syndrome (AIDS), cardiac surgery or liver disease; and
- Post-Hospital treatments, such as nursing or other Home Health Care services.

Maternity Management Incentive Program

This voluntary program provides information to expectant mothers and helps identify possible high-risk pregnancies. When you learn that you or a covered dependent is pregnant, please call the Medical Advisor before the end of the first trimester.

If a pregnancy is considered high risk, the Medical Advisor will work with the Physician to monitor the patient's progress throughout the course of the pregnancy.

If the pregnancy is not considered high risk, educational material will be provided and the Medical Advisor will follow up during the second and third trimesters, as appropriate.

The Plan will provide a \$100 incentive to Participants who successfully complete the Maternity Management Incentive Program. The \$100 will be a taxable benefit. For more information on the program, contact the Medical Plan Advisor.

VIII. HOW THE MEDICAL PLAN WORKS

The City offers its Employees a choice of different medical plans, including the Preferred Provider Organization (PPO) and Health Maintenance Organization (HMO) plans. However, please note that all newly hired Employees are required to participate in the PPO plan (that's documented here) for the first 18 months of their employment. These Employees are eligible to switch to another option effective as of the January 1st following the 18-month anniversary of their date of hire. An election to switch must be made during the open enrollment period immediately preceding that January 1st.

A. PPO Providers

When you use Doctors and Hospitals that are PPO Providers, your out-of-pocket expenses will be lower because:

- Deductibles are lower;
- The Plan pays a higher percentage with respect to care provided by PPO Providers;
- The PPO has negotiated rates with PPO Providers (the Allowable Charge) such that the charges or services are lower; and
- Out-of-Pocket Limits are lower.

For a listing of PPO Providers, refer to the directory on the Claims Administrator's website.

B. Usual and Customary Charges

The Plan pays benefits for Usual and Customary (U&C) Charges for Hospital, surgical, and other eligible medical expenses resulting from an Illness or Injury.

The Plan does not cover charges above the U&C limit as defined in the Definitions section and determined by the Claims Administrator:

If charges exceed the U&C amount, you will be responsible for the amount that is in excess. That amount cannot be applied toward the Deductible, and it will not be applied toward the Out-of-Pocket Limit. (Of course, PPO Providers by definition may not bill you in excess of the U&C limit.)

It is important for you to understand that the U&C charge as defined under the Plan can never exceed the Allowable Charge (as defined in the Definitions section of this document). This means that a Non-PPO Provider may bill you for the difference between the Plan payment based on the Allowable Charge and the Provider's charges. With respect to Professional Providers, the Plan will pay a Non-PPO Provider based upon the negotiated rate that would have been paid to a PPO Provider had you used one. Further explanation of the concept of Allowable Charge as applied to both Professional Providers and Non-Professional Providers is contained in the Definitions at the end of this document.

C. Your Share of Expenses

The Plan is self-funded. The Plan has an Administrative Service Only ("ASO") agreement with its Claims Administrator, meaning the Claims Administrator only processes claims. Through its contract with the Claims Administrator, the City may receive discounts or other allowances from the Claims Administrator. These discounts or allowances are retained by the City to help offset the costs of the medical plans.

Further, the calculation of the maximum amount of benefits payable by the Claims Administrator and the calculation of all required Deductible and Coinsurance amounts payable by you shall be based on the Allowable Charges for services rendered to you. This is irrespective of any separate financial arrangement between the City and the Claims Administrator.

Deductible

The Deductible is the portion of your medical expenses that you pay each Calendar Year before the Plan pays benefits for certain covered services. Deductible amounts are listed on the Schedule of Benefits. For further information, see the definition of Deductible and Family Deductible at the end of this document.

Carryover Provision

Covered medical expenses that are incurred in October, November, and December and applied to your Deductible will be applied to the Deductible for the following year.

Coinsurance

After you have paid the Deductible, where applicable, the Plan pays a percentage of Covered Expenses and you pay the rest; this is known as your Coinsurance. The Coinsurance amount depends on the type of expenses and whether or not a PPO Provider is used. Further information is available in the Schedule of Benefits.

Copayment or Co-payment

You must pay a flat dollar amount towards the cost of certain covered services or supplies, such as Physician office visits. This is called a Copayment, and does not apply toward the Deductible or Out-of-Pocket Limit.

A note about Copayments for Physician Office Visits

Generally, with respect to office visits to Physicians who are PPO Providers, you pay only the Copayment as specified in the Schedule of Benefits. However, you should be aware of the following:

- Some Physicians who are affiliated with teaching Hospitals will bill for an office visit, and the Hospital will bill separately for a "facility fee." If the Plan is billed for a facility fee, the charge will be subject to the Deductible and you will pay Coinsurance as set forth in the Schedule of Benefits, in addition to the office visit Copayment.

- Some Physicians will refer you to the Hospital Out-patient department for testing. The Hospital bills for lab work will be subject to the Deductible and you will pay Coinsurance.
- If an urgent care center bills using Hospital billing codes, the charge will be subject to the Deductible and you will pay Coinsurance.
- If a surgical procedure is performed during the office visit and/or medical supplies are provided, those charges will be subject to the Deductible and you will pay Coinsurance.
- Emergency room Physician visits are not considered “office visits,” and thus are subject to the deductible and co-insurance. (You sometimes can avoid these charges by visiting an after-hours Physician’s office instead . To find such an office, go to www.cityofchicago.org/city/en/depts/fin/provdrs/ben.html.)

Out-of-Pocket Limit

The Plan places a limit on the amount of money you will have to pay for Covered Expenses each Calendar Year. Once your share of expenses (Deductible and Coinsurance,) reaches the Out-of-Pocket Limit, the Plan pays 100% of most Covered Expenses for the rest of the Calendar Year. The Out-of-Pocket Limits for Network and Non-PPO Providers are listed in the Schedule of Benefits starting on page 6.

The Out-of-Pocket Limit is based on whether you use Network or Non-PPO Providers. If you incur expenses for services both in and out of the PPO network, one Out-of-Pocket Limit will apply to expenses incurred with PPO Providers and another Out-of-Pocket Limit will apply to expenses incurred with Non-PPO Providers.

Notice of Patient Protection Rights

The Plan does not require the designation of a Primary Care Provider. However, using a Primary Care provider can improve your health care outcomes and save you money. For information on how to select a Primary Care provider, and for a list of the participating Primary Care providers, contact the medical Claims Administrator at the number on the back of your medical benefit ID card.

You do not need pre-approval from the Plan or from any other person (including a Primary Care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. Additionally, you do not need pre-approval in order to access care from a Specialist, unless specifically indicated in the Medical Advisor Review Program set forth in Article VII. You or the health care professional, however, may be required to comply with certain Plan procedures, such as obtaining Pre-Certification for certain services. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your medical benefit ID card. For questions regarding your Pre-Certification obligations, please contact the Medical Plan Advisor.

IX. COVERED EXPENSES

In order to be considered Covered Expenses under the Plan, all expenses must be Medically Necessary and must not exceed Usual and Customary Charges. The level of reimbursement depends on the type of service and whether services are provided by Network or Non-PPO Providers. Refer to the PPO Plan Schedule of Benefits starting on page 6 for details.

Alternatives to Inpatient Treatment

There are certain alternatives to inpatient mental health and substance abuse treatments, such as:

- Residential Treatment Center;
- Partial hospitalization; and
- Intensive/structured outpatient treatment.

Benefits will only be paid if the alternative treatment is approved by the Medical Advisor and after the Deductible, at:

- 90% for services received from PPO Providers; or
- 60% for services received from Non-PPO Providers.

Ambulatory Surgical Facilities

Benefits will be provided for an ambulatory surgical facility that is primarily for the provision of surgical procedures on an ambulatory basis and that is duly licensed by the appropriate state and local authority to provide such services. Benefits are paid at:

- 90% of Allowable Charges for services received from PPO Providers; or
- 60% of Allowable Charges for services received from Non-PPO Providers.

Ambulance Transportation

Medically Necessary Ambulance Transportation to the Hospital and between Hospitals is covered at 90%. Ambulance Transportation between Hospitals requires Pre-Certification by the Medical Advisor. If long-distance transportation is required by ambulance from one Hospital to another Hospital, you must call the Medical Advisor for approval before being transported. If the transportation is approved by the Medical Advisor, the Plan will pay 90% after the Deductible for the eligible cost of the ambulance.

Medically Necessary railroad or commercial airline transportation to, but not from, a Hospital equipped to provide special treatment that cannot be obtained within the PPO Network is covered at 90%, after the Deductible. If the medical advisor is not contacted for approval, the Plan will not pay the transportation charge.

Benefits will not be provided for use of an ambulance because it is more convenient than other transportation or for elective transfers between facilities. It is an elective transfer if the services to be received in the second Hospital are available in the first Hospital.

Cardiac Rehabilitation Services

Benefits will be provided for cardiac rehabilitation services only in programs approved by the Claims Administrator when these services are rendered within a six-month period following a covered inpatient Hospital admission for either myocardial infarction, coronary artery bypass surgery, or percutaneous transluminal coronary angioplasty. To find out whether a program is “approved,” contact the Claims Administration as identified in the Important Contact Information Section. Benefits are paid at:

- 90% of Allowable Charges for services received from PPO Providers; or
- 60% of Allowable Charges for services received from Non-PPO Providers.

Chiropractic Visits

The Plan will cover up to twenty (20) chiropractic visits per year subject to office visit Copayments, if performed by a PPO Provider. If performed by a Non-PPO Provider, up to twenty (20) chiropractic visits per year will be covered at 60% of the Allowable Charge amount, after the deductible is met. There is coverage for a maximum of three (3) Modalities per visit. There is no coverage, however, for chiropractic services administered merely to maintain a level of function where there is no expectation of demonstrable and measurable improvement. A chiropractor is considered a Specialist under the Plan, not a Primary Care Physician.

Voluntary Health Risk Assessment for Soft Tissue Injuries

If you would like to obtain health care information on soft tissue injuries or general guidelines for assessment of such injuries, you or your dependents can call the Medical Advisor. (See page 6 for a complete description of the Medical Advisor Review Program.)

Minor shoulder, neck and/or back pain related to sprains, muscle injuries or arthritis are examples of soft tissue related medical conditions. The Medical Advisor nurse will share educational information with you regarding your condition as well as provide information on treatment options. The program is completely voluntary.

When you call, the nurse will ask you for the following information:

- Date of injury,
- Type of injury, and
- Physician and/or provider that has provided care for the injury.

Dental Treatment

Most dental care will be covered (if it is covered at all) under the City's Dental PPO or Dental HMO (if you are enrolled in one of those plans). However, limited benefits for certain services related to dental treatment will be covered by this Plan. Specifically:

- Benefits under this Plan will be available for treatment of Accidental Injury to sound natural teeth (including their replacement provided this is the least costly and most appropriate treatment) due to an accident. This will include charges related to the dentist's services.
- If a child under age 6, a disabled individual, or an individual with a serious medical condition requires dental treatment, and it is not medically advisable to provide that treatment in the dentist's office, benefits under this Plan will be available for Hospital Care and Anesthesia Services for treatment rendered in a Hospital on an outpatient basis or in an Ambulatory Surgical Treatment Center. However, this Plan will not cover the charges related to the dentist's services. (There may be coverage for such charges under the Dental PPO or Dental HMO.)

Diagnostic Testing

A diagnostic/laboratory test is a diagnostic test for which a sample (blood, urine, feces, etc.) is collected. Except as described below with respect to the Diagnostic Testing/Independent Lab Incentive Program, diagnostic testing i.e., laboratory services) will be covered at 90% of Allowable Charges after the Deductible is met, if performed by a PPO Provider, and at 60% of Allowable Charges after the Deductible is met, if performed by a Non-PPO Provider.

Diagnostic Testing/Independent Lab Incentive Program

- This program is designed to save you and the Plan money. When your Physician orders lab tests, you can choose where to have the tests performed. In some instances your Physician will do the testing in his office or will refer you to an independent lab or a Hospital Outpatient department for the lab testing or to a free-standing diagnostic facility. It costs substantially more to have lab tests done in the Hospital -- sometimes more than four times as much as if you had the lab tests done at a free-standing facility or in the Physician's office. **If you have the medical tests done outside of the Hospital at an independent PPO Provider location not affiliated with a Hospital, the Plan will pay 100% of the expense for the lab tests.** However, if you go to the Hospital out-patient department or a Non-PPO Provider, the applicable Deductible and Coinsurance will apply. Any lab tests billed by a Hospital will not be eligible for this improved benefit. (It is not always obvious that the lab your Physician is sending you to is a Hospital lab—it may be down the hall or on a different floor in the same building where the Doctor's office is located. To be sure, ask your Physician or the lab who will bill for the tests.)

The PPO Plan Claims Administrator can help you locate nearby facilities where you can obtain lab tests at no cost to you.

Durable Medical Equipment

The Plan provides coverage for Durable Medical Equipment (DME). If the DME expense is over \$500 you must call the Medical Advisor for Pre-Certification. No benefits will be paid for DME above \$500 if the Medical Advisor is not contacted.

Pre-Certification of DME is based on Medical Necessity and cost-effectiveness. To determine whether DME is cost-effective, we will compare equipment alternatives and consider whether there are distinct medical advantages that justify greater cost or more frequent replacement. We will not Pre-Certify reimbursement for DME that does not provide an advantage over a suitable, less costly alternative.

The rental or purchase (if purchase is more cost effective) of DME from a PPO Provider is covered at 90%, after the Deductible is met, and at 60% of the Allowable Charge amount from a Non-PPO Provider, after the Deductible is met.

Durable medical equipment includes wheelchairs, hospital-type beds, oxygen equipment, or other medical supplies used exclusively for the treatment of an Illness or Injury. Expenses incurred to rent DME will be applied against the purchase price if the Participant later decides to buy equipment. Rental and/purchase costs paid by the Plan will never be greater than the cost to purchase the equipment.

Emergency Services

Emergency Accident Care and Emergency Medical Care will be paid at 90% whether or not you go to a Network Hospital, after the Network Deductible is met. However, an Emergency Room Copayment of \$100 per visit applies. The Emergency Room Copayment is waived if you are admitted to the Hospital. The Emergency Room Copayment does not apply to the Deductible or Out-of-Pocket Limit.

If you are admitted to the Hospital for Emergency Accident Care or Emergency Medical Care, you or your representative must call the Medical Advisor within two business days of the admission.

Non-PPO Provider services will be paid at the PPO Provider Coinsurance rate and subject to the PPO in-network deductible, but are still subject to the Usual and Customary Charge limitation applicable to Non-PPO Providers with respect to the following services:

- Emergency Accident Care or Emergency Medical Care as defined;
- Medically Necessary care ordered by a Doctor that, after review by the Medical Advisor, is determined by the Medical Advisor to be:
 - Care provided beyond a 50-mile distance from any PPO Provider Hospital if the Participant is temporarily living away from home; or
 - Only available from a Non-PPO Provider or Hospital; or

- Comprised of services or treatment performed so infrequently by a PPO Provider or Hospital that performance of the services by a Non-PPO Provider is medically appropriate.

Care at a Non-PPO Provider Hospital will be covered by the Plan on an In-Network basis only until you can be safely moved to a Network Hospital. Arrangements to move you to a Network Hospital should begin when the treatment plan begins. The cost of the transfer to the Network Hospital will be paid by the Plan if the transfer is arranged by the Medical Advisor.

Home Health Care

Home health care from a PPO Provider is covered at 90% of Allowable Charges after the Deductible is met.

Out-of-network home health care services will be covered at 60% of the Allowable Charge amount after the out-of-network Deductible has been met.

Services include Medical Care provided by a Nurse received at home rather than in a Hospital.

Home Health Care Programs will be eligible for coverage based on the Medical Advisor's approval. You or your representative must call the Medical Advisor Review Program and receive approval before care, in order for services to be covered.

Hospice Care

Hospice care from a PPO Provider is covered at 90% of Allowable Charges after the Deductible.

Out-of-network Hospice care will be covered at 60% of the Allowable Charges after the out-of-network Deductible has been met.

Hospice care is designed to meet the needs of the terminally ill and their families.

Hospice care programs will be eligible for coverage based on your Doctor's recommendation and the Medical Advisor's approval. You or your representative must call the Medical Advisor Review Program and receive approval before care, in order for services to be covered.

Human Organ Transplants

Benefits for certain human organ transplants, provided that the transplants are pre-Certified by the Medical Advisor, are the same as benefits for any other condition. Benefits will be provided for cornea, kidney, bone marrow/stem cell, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplant.

Benefits are available to both the recipient and donor of a covered transplant as follows:

- If both the donor and recipient have coverage, each will have their benefits paid by their own program.
- If a Participant is the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits described in this PPO booklet will be provided for both the Participant and the donor.
- If a Participant is the donor for the transplant and no coverage is available to the Participant from any other source, the benefits described in this PPO booklet will be provided for the Participant. However, no benefits will be provided for the recipient (unless the recipient is also a Participant).
- The organ transplant benefits described in this PPO booklet will be provided for the Participant in the event that the Participant has coverage under another plan but that coverage is not as extensive as the coverage under this Plan. If the Participant is the donor, this Plan will pay secondary to the recipient's plan.

For the following transplants you must receive treatment at an approved transplant center: Heart, Lung, Heart/Lung, Liver, Simultaneous Pancreas/Kidney (SPK), Pancreas (PAT/PTA) and Bone Marrow/Stem Cell. **You must utilize these hospitals or the procedures will not be covered.** You may contact the Medical Advisor or the Claims Administrator for information as to whether a facility is an approved transplant center.

Benefits, if pre-Certified by the Medical Advisor, will be provided for:

- Inpatient and Outpatient Covered Services related to the transplant surgery.
- The evaluation, preparation, and delivery of the donor organ.
- The removal of the organ from the donor.
- The transportation of the donor organ to the location of the transplant surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

In addition to the other exclusions of this PPO booklet, benefits will not be provided for the following:

- Services that are not pre-Certified by the Medical Advisor.
- Travel time and related expenses required by a Provider or Patient.
- Drugs that do not have approval of the Food and Drug Administration.
- Organ storage fees.
- Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.

Infertility

The Plan provides coverage for the diagnosis and/or treatment of Infertility as defined on page 117. Services must conform to the guidelines of the American College of Obstetrics and Gynecology or the Standards of the American Society of Reproductive Medicine. When you or a covered dependent are scheduled to begin services for the treatment of Infertility, you are encouraged to contact the Medical Advisor. You should consult the Medical Advisor Review Program requirements of the Plan before receiving services to determine whether any services are subject to the review requirements of the Medical Advisor Review Program. Failure to comply with the requirements of the Medical Advisor Review Program may result in penalties or denial of benefits. Even if prior approval is not otherwise required under the Medical Advisor Review Program, it is recommended that fertility services be reviewed prior to receiving services to determine if services are eligible for coverage.

The evaluation and treatment of Infertility may include, but is not limited to:

- Diagnostic procedures;
- Prescription Drugs (in accordance with the terms of the Prescription Drug Program);
- Artificial insemination;
- Conventional treatment of uterine anomalies;
- Conventional treatment of male factors, such as varicocele;
- Medical cost of oocyte or invasive sperm retrieval and medical costs of egg or sperm donation. Benefits will be provided up to a total of four completed oocyte or invasive sperm retrievals upon the Participant or upon an egg or sperm donor on behalf of the Participant. The four-retrieval limit is per lifetime of the individual regardless of whether you were covered by this Plan or another plan at the time. So, for example, if you have had a completed oocyte retrieval in the past that was paid by another insurance plan or not covered by insurance at all, the retrieval will count towards the maximum. However, if a live birth follows a completed oocyte or invasive sperm retrieval, four additional Medically Necessary oocyte or invasive sperm retrievals will be covered for Infertility services following each live birth. The total number of invasive retrievals from both a donor in lieu of a Participant and from the Participant will be considered when determining if the limit of four retrievals has been reached; and
- Various assistive reproductive procedures, which include, but are not limited to:
 - Embryo transfer;
 - Gamete Intrafallopian Transfer (GIFT);
 - Zygote Intrafallopian Transfer (ZIFT);

- In Vitro Fertilization (IVF);
- Low tubal ovum transfer;
- Assisted hatching;
- Intracytoplasmic Sperm Injection (ICSI);
- Frozen tubal embryo transfer;
- Donor egg and donor embryo transfer;
- Zona dissection; and
- Subzonal insertion of sperm.

The following services are not covered:

- Services rendered to a surrogate for purposes of child birth;
- Non-medical costs of an egg or sperm donor;
- Travel costs;
- Costs associated with cryopreservation and storage of egg, sperm, or embryo;
- Experimental treatments, services, or supplies;
- Drugs, devices, or treatments that are not Medically Necessary;
- Fertility services when the Participant (Employee and/or spouse) has undergone a voluntary sterilization procedure;
- Surgical operations to reverse voluntary sterilization; or
- Services provided to an individual who is infertile as a result of the natural cessation of menses.

Infertility diagnosis and treatment provided by a PPO Provider is covered at 90%, after the Deductible. Out-of-network services will be covered at 60% of Allowable Charges

Inpatient Hospital Stays

An Inpatient stay in the Hospital must be approved by the Medical Advisor. If approved, Inpatient Hospital services will be covered as follows, after the applicable Deductible is met:

- 90% of Allowable Charges for an approved stay in a PPO Provider Hospital; or
- 60% of Allowable Charges for an approved stay in a Non-PPO Provider Hospital.

You or your representative must contact the Medical Advisor at least 24 hours before a non-emergency admission or within two business days of an emergency admission.

During the course of the Hospital stay, the Medical Advisor will contact the Doctor and/or the Hospital to discuss possible alternatives to an extended Hospital stay and determine if the extended stay is Medically Necessary. Expenses for days not certified as Medically Necessary by the Medical Advisor will not be paid.

If you are admitted to the Hospital on an emergency basis, your hospital stay will be paid at 90% regardless of whether the Hospital is a PPO Provider or a Non-PPO Provider. (However, the Plan's 90% payment will be based on the Allowable Charge for the services, even for Non-PPO Hospitals.) You or your representative must call the Medical Advisor within two business days of the admission. Only those charges related to days that are Certified by the Medical Advisor will be paid by the Plan.

If the Medical Advisor is not contacted within the required timeframes as described above, you will have to pay the first \$1,000 of Covered Expenses for the Hospital stay. **The penalty amount will not count toward the Deductible, or Out-of-Pocket Limit.** Additionally, your claim will be denied based on a failure to contact the Medical Advisor. However, if you appeal the denial, you will be given the opportunity to contact the Medical Advisor to obtain a review of Medical Necessity. If any Hospital days or services are determined by the Medical Advisor to be not Medically Necessary, the appeal will be denied and you will be responsible for all charges for those days.

Covered Expenses include:

- Semi-private room and board (or a private room if Medically Necessary);
- Intensive care;
- Medical and surgical nursing care;
- Diagnostic tests;
- Supplies; and
- Medications.

Maternity

You or your representative are encouraged to contact the Medical Advisor within your first trimester. Additionally, following a maternity admission to the Hospital, you also should call the Medical Advisor within two business days to certify your In-patient stay to avoid the \$1,000 penalty. PPO Provider services are covered at 100% of Allowable Charges with respect to Physician services for maternal care subject to an initial office visit Copayment for the first office visit only, and with respect to all other related services (i.e., Hospital, anesthesiologist, lab work, and newborn care), at 90% of Allowable Charges after the Deductible is met. Non-PPO Provider services are covered at 60% of Allowable Charges after the Deductible is met.

Mental Health and Substance Abuse Treatment

To receive full benefits, you or your representative must contact the Medical Advisor for approval:

- At least 24 hours before a non-emergency admission or within two business days of an emergency admission for inpatient mental health or substance abuse treatment; and
- Before the eighth session of outpatient mental health or substance abuse treatment.

If the Medical Advisor is not contacted:

- You will have to pay \$1,000 of covered inpatient mental health or substance abuse treatment, and all other expenses determined not to be Medically Necessary; and
- The Plan will not pay benefits beyond the first seven sessions for outpatient mental health or substance abuse treatment expenses.

The penalty described above will not count toward any Deductible or Out-of-Pocket Limit.

Benefits for treatment of mental health will be paid if approved by the Medical Advisor, after the Deductible, as follows:

- 100% of Allowable Charges after payment of the applicable office visit Copayment with respect to PPO Outpatient Services;
- 90% of allowable charges with respect to PPO Inpatient Services after the Deductible has been met; and
- 60% of Allowable Charges after the Deductible has been met for services received from Non-PPO Providers.

Office Visits

An office visit is a service provided by a Professional Provider in a medical office or retail clinic setting on an Outpatient basis. Office visits with PPO Providers are paid generally at 100% of Allowable Charges after payment of the applicable Copayment. This does not apply, however, to services beyond the professional services provided by the Professional Provider, such as Durable Medical Equipment or surgical or other separate and distinct procedures. Office visits with Non-PPO Providers will be covered at 60% of Allowable Charges after the deductible is met.

Oral Surgery

Benefits for oral surgery are limited to the following services:

- Surgical removal of unerupted impacted wisdom teeth.
- Removal of tumors or cysts of the jaws, cheeks, lips, tongue, and roof and floor of the mouth.
- Surgical procedures to correct Accidental Injuries of the jaws, cheeks, lips, tongue, and roof and floor of the mouth.
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses), treatment of fractures of facial bone, external incision and drainage of cellulitis, incision of accessory sinuses, salivary glands, or ducts, reduction of dislocation of, or excision of, the temporomandibular joints.
- Inpatient Hospital charges for oral surgery while a registered patient if Medically Necessary.
- Benefits also will be provided for Anesthesia Services administered by oral and maxillofacial surgeons in conjunction with the above listed surgical procedures when such services are rendered in conjunction with covered, Medically Necessary oral surgery in the surgeon's office, or Ambulatory Surgical Facility.
- If a child under age 6, a disabled individual, or an individual with some other serious medical condition requires oral surgery and it is not medically advisable to provide such surgery in a dental office or Ambulatory Surgical Facility, benefits will be provided for oral surgery and related Anesthesia Services and Hospital Care in a Hospital on an Outpatient basis.

Outpatient Mental Health and Substance Abuse Treatment

- Eligible expenses for the first seven sessions of outpatient mental health and/or substance abuse treatment will be paid at 100% of Allowable Charges subject to a \$25 Copayment. Non-PPO Provider services are covered at 60% of Allowable Charges after the Deductible is met. The first seven sessions of outpatient mental health and substance abuse treatment each Calendar Year do not require Pre-Certification from the Medical Advisor. However, you must obtain Pre-Certification from the Medical Advisor before the eighth session of outpatient mental health and/or substance abuse treatment or subsequent sessions will not be covered.
- Benefits include services of a licensed clinical social worker performed under the supervision of a Physician. Benefits are only paid for a primary DSM-IV (Diagnosis and Statistical Manual of Mental Disorders, Fourth Edition) diagnosis or a diagnosis under a subsequent revision of such manual.

Outpatient Hospital Services

Outpatient Hospital services are covered at 90% of Allowable Charges at a PPO Provider or 60% of Allowable Charges at a Non-PPO Provider after the Deductible. Eligible Outpatient Hospital Covered Expenses include:

- Diagnostic tests;
- Emergency room treatment;
- Outpatient surgery;
- Supplies; and
- Medications.

Outpatient Speech Therapy and Occupational Therapy

The Plan covers outpatient speech therapy and occupational therapy if the therapy is Medically Necessary in order to acquire or restore function. There is no coverage, however, for speech or occupational therapy that is administered merely to maintain a level of function where there is no expectation of demonstrable and measurable improvement. Up to ten speech or occupational therapy sessions are covered in a Calendar Year without Pre-Certification from the Medical Advisor Review Program, if sessions are Medically Necessary. Sessions over ten require precertification. If the Medical Advisor is not contacted, the Plan will not pay benefits beyond the first 10 sessions for outpatient speech or occupational therapy. However, calling the Medical Advisor is not a guarantee of payment.

Treatment by a licensed qualified speech or occupational therapist is covered at 100% for PPO Provider services after a \$20 copayment per visit, up to a maximum 60 visits annually for speech therapy and a maximum of sixty visits annually for occupational therapy. The copayment does not apply toward the Deductible or Out-of-Pocket Limit.

Out-of-network speech and occupational therapy will be covered at 60% of Allowable Charges after the out-of-network Deductible has been met.

Outpatient Surgery

Outpatient Surgery will be covered at 90% of Allowable Charges after the Deductible is met if performed by a PPO Provider, and at 60% of Allowable Charges after the Deductible is met if performed by a Non-PPO Provider.

Physical Therapy

The Plan covers Outpatient physical therapy if the therapy is Medically Necessary in order to acquire or restore function. There is no coverage, however, for physical therapy that is administered merely to maintain a level of function where there is no expectation of demonstrable and measurable improvement. Physical therapy will be covered at 90% of Allowable Charges after the Deductible is met if performed by a PPO Provider, and at 60% of Allowable Charges after the Deductible is met if performed by a Non-PPO Provider.

Physician Services

The PPO network includes Doctors from virtually every medical specialty. Services of a PPO Provider other than the office visit itself will be covered at 90% of Allowable Charges after the Deductible is met. Services obtained from Non-PPO Providers will be covered at 60% of Allowable Charges after the Deductible is met. Office visits to PPO Providers will be subject to a \$25/\$35 Copayment (Primary Care/Specialist Visit) (see Office Visits above).

Preventive Services

The Plan pays 100% of the Allowable Charge without Copayments for preventive services which are required to be covered by the Affordable Care Act of 2010 if the preventive services are provided by a PPO Provider, subject to the frequency, gender and age guidelines established under the Affordable Care Act. The Plan does not cover preventive services provided by Non-PPO Providers or not required by the Affordable Care Act. For a complete list of covered preventive services, please visit www.healthcare.gov/prevention/index.html.

Prosthetic Appliances

The Plan provides coverage for prosthetic appliances.

- Prosthetic appliances, such as artificial limbs, eyes or other Medically Necessary prosthetic devices provided by a PPO Provider, are covered at 90% of Allowable Charges after the Deductible is met. Services provided by a Non-PPO Provider are covered at 60% of Allowable Charges after the Deductible is met.
- Certain replacement prosthetics are not covered. However, the Plan will cover certain Medically Necessary prosthetic replacements inserted in the inner body, such as knee, hip, elbow, and ankle replacements, heart valves, and pacemaker and penile implants.
- Replacement of external prosthetic appliances is not covered unless such replacement is necessary due to physiological changes.

Scans

The Plan provides coverage for Magnetic Resonance Imaging (MRI) scans, Positron Emission Tomography (PET) scans, and Computed Axial Tomography (CAT/CT) scans only if you call the Medical Advisor for Pre-Certification through the Medical Advisor Review program. Benefits will not be paid if the Medical Advisor does not approve the services as Medically Necessary. Except as set forth below with respect to the Incentive Program, services provided by a PPO Provider are covered at 90% of Allowable Charges after the Deductible is met. Services provided by a Non-PPO Provider are covered at 60% of Allowable Charges after the Deductible is met.

MRI, PET and CAT Scans Incentive Program

This program is designed to save you and the Plan money. When your Physician orders diagnostic scans (MRI, PET, CAT), you can choose where to have the tests or scans

performed. In some instances your Physician will do the scans in his office or will refer you to an independent Hospital out-patient department or to a free-standing diagnostic facility. It costs substantially more to have diagnostic scans done in a Hospital- - sometimes more than four times as much as if you had the scans done at a free-standing facility or in the Physician's office. **If you have the scans done outside of the hospital at a designated PPO Provider location, the Plan will pay 100% of the expense for the MRI, PET and CAT scans.** However, if you go to the Hospital Outpatient department or a Non-PPO Provider, the applicable Deductible and Coinsurance will apply. Any scans billed by a Hospital will not be eligible for the incentive program and will be paid at 60%/90% as described above.

When you or your Provider calls the Medical Plan Advisor to have an MRI, PET or CAT scan reviewed, the Medical Plan Advisor will provide locations of nearby facilities where you can obtain the approved procedure at no cost to you.

Skilled Nursing Facility Care

If you require care in a Skilled Nursing Facility, you or your representative must obtain advance approval from the Medical Advisor for services to be covered. PPO Provider services are covered at 90% of Allowable Charges after the Deductible is met. Non-PPO Provider services are covered at 60% of Allowable Charges after the Deductible is met.

If the Medical Advisor is not contacted within the required timeframe, you will have to pay the first \$1,000 of Covered Expenses for the Skilled Nursing Facility stay. **The penalty amount will not count toward the Deductible, or Out-of-Pocket Limit.** Additionally, your claim will be denied based on a failure to contact the Medical Advisor. However, if you appeal the denial, you will be given the opportunity to contact the Medical Advisor to obtain a review of Medical Necessity. If any days or services are determined by the Medical Advisor to be not Medically Necessary, the appeal will be denied and you will be responsible for all charges for those days.

Surgery

This Plan includes benefits for surgery performed by a Physician. The following services are also part of the surgical benefits:

- Sterilization procedures.
- Anesthesia Services - if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a certified registered nurse anesthetist.
- Assist at surgery - when performed by a Physician who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assistance at surgery when performed by a physician assistant or registered nurse practitioner under the direct supervision of a Physician. The Claims Administrator will determine if the surgical procedure performed required the use of an assistant. Only those

surgeries for which the Medical Necessity of an assistant can be established will qualify for benefits for an assistant.

- An opinion sought from a second Physician so that the patient can make a decision about a proposed surgical procedure is covered after the Deductible has been met.

Benefits for Physician's charges for surgery will be paid at:

- 90% of Allowable Charges for services received from PPO Providers; or
- 60% of Allowable Charges for services received from Non-PPO Providers.

X. MEDICAL PLAN EXCLUSIONS: WHAT'S NOT COVERED BY THE PLAN

Although the Plan covers most medical expenses, some costs are not covered, as described in this section.

- Services or supplies for an Illness or Injury **incurred in the course of any employment** (including self-employment and contracted employment) without regard to whether any benefits are available under any **workers' compensation** law or other similar laws.
- Services or supplies for an Illness or Injury that is covered under **workers' compensation** or a similar law.
- Hospitalization, services, supplies, or treatments that are **not Medically Necessary** as defined.

No benefit will be provided for services that are not, in the reasonable judgment of the Claims Administrator or Medical Advisor, Medically Necessary.

The Claims Administrator or Medical Advisor will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of the Plan.

IN SOME INSTANCES THIS DECISION IS MADE BY THE CLAIMS ADMINISTRATOR OR MEDICAL ADVISOR AFTER THE PARTICIPANT HAS BEEN HOSPITALIZED OR HAS RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED.

REMEMBER, EVEN IF A PHYSICIAN PRESCRIBES, ORDERS, RECOMMENDS, APPROVES, OR VIEWS HOSPITALIZATION OR OTHER HEALTH CARE SERVICES AND SUPPLIES AS MEDICALLY NECESSARY, THE CLAIMS ADMINISTRATOR WILL NOT PAY FOR THE HOSPITALIZATION, SERVICES, OR SUPPLIES IF IT IS DETERMINED BY THE CLAIMS ADMINISTRATOR OR MEDICAL ADVISOR THAT THEY WERE NOT MEDICALLY NECESSARY UNDER THE TERMS OF THE PLAN. THE CLAIMS ADMINISTRATOR, OR MEDICAL ADVISOR HAVE COMPLETE DISCRETION TO MAKE DETERMINATIONS OF MEDICALLY NECESSITY FOR PURPOSES OF THE PLAN, AND SUCH DETERMINATION SHALL BE FINAL AND BINDING.

If a Claim for benefits is denied on the basis that the service or supplies were not Medically Necessary, and the Participant disagrees with the Claims Administrator's or Medical Advisor's decision, the Plan provides for an appeal of that decision. The Participant may furnish or submit any additional documentation that may be appropriate.

- Charges for **Maintenance Therapy**.

- Charges for services or supplies **above the Allowable Charge**.
- Any operation or treatment of the **teeth** or the supporting tissues of the teeth including dental implants or expenses related to the preparation of the mouth for dental implants, or replacement of teeth lost as a result of medical treatment, except:
 - Removal of tumors or cysts of the jaws, cheeks, lips, tongue, and roof and floor of the mouth.
 - Treatment of malerupted impacted wisdom teeth.
 - Treatment of Accidental Injury to sound natural teeth (including their replacement provided this is the least costly and most appropriate treatment) due to an accident.
 - Inpatient Hospital charges for oral surgery while a registered patient if Medically Necessary.
- **Cosmetic surgery**, except:
 - Operations necessary to repair disfigurement due to an accident that occurs while the Participant is covered by this Plan.
 - The Medically Necessary treatment of a congenital anomaly in a Dependent child.
 - Reconstructive breast surgery following a mastectomy.
 - Surgical operations necessary to repair disfigurement due to treatment of an Illness if such surgical operation improves or restores bodily function and the Illness was covered by the Plan.
- **Hearing aids** or exams in connection with the prescription, fitting or adjustments of hearing aids.
- **Eyeglasses** or **contact lenses** and the exam for their fitting or for determining the refractive state of the eyes.
- Surgical correction of **refractive errors**.
- **Vision therapy** or **orthoptics**.
- Services or supplies for Illness, Injury, or mental health conditions caused by **war** or an act of war.
- Charges in connection with Illness or Injury related to **military** service.
- The treatment of **flat foot** conditions and the prescription of supportive devices, including **orthotics** and the treatment of **subluxations** of the foot.

- Treatment of **foot conditions**, such as cutting, trimming, or paring of corns and calluses, and routine foot care, except for persons receiving this treatment or care as a result of diabetes.
- **Whole blood** or **derivatives** that are donated.
- Services or supplies for any **Custodial Care**.
- Charges for **telephone, Skype, internet, or e-mail consultations**, for completing a **claim form** or medical record, or for **failure to keep a scheduled appointment**.
- Charges for services in a **nursing home** and/or sanitarium other than a Skilled Nursing Facility.
- **Non-prescription** drugs, except insulin.
- **Marital, cognitive, investigational, family, or educational** therapy.
- Retainers, mouth guards, dental exams, prophylaxis, and orthodontia for any temporomandibular joint (**TMJ**) disorder.
- **Acupuncture, naprapathy**, or services provided by an acupuncturist or naprapath.
- Classes or hypnotism for **smoking cessation** not specifically recommended by the Affordable Care Act.
- **Health club** charges or fees.
- Charges for drugs, devices, procedures, or medical treatments that are considered **Experimental** or **Investigational** by generally accepted medical practice (see page 115 for a definition of Experimental).
- Charges for supplies or programs to help the Participant **lose weight**, except surgical operations that are Medically Necessary.
- Charges for services, supplies, or treatments **not necessary** for treatment of Injury or Illness.
- Charges for **chiropractic** visits in excess of twenty visits per year or in excess of three Modalities per visit.
- Services or supplies that are furnished or provided by the **local, state or federal government** except however, this exclusion shall not be applicable to medical assistance benefit under Article V, VI or VII of the Illinois Public Aid Code or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise prohibited by law.

- Services or supplies that **do not meet accepted standards** of medical and/or dental practice.
- Services or supplies received from a dental or medical department or **clinic** maintained by an employer, labor union or other similar person or group.
- Services or supplies for which the Participant is not required to make payment or would have **no legal obligation to pay** without this or similar coverage.
- Charges for **interest** or **taxes** on an unpaid bill.
- Penalties for not complying with the **Medical Advisor Review Program**.
- Personal **hygiene, comfort, or convenience** items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
- Special braces, splints, appliances, ambulatory apparatus, battery implants, or other **specialized equipment**, except as specifically mentioned in this PPO booklet.
- Procurement or use of prosthetic devices, special appliances and surgical implants that are for **cosmetic** purposes, the **comfort** and **convenience** of the patient, or unrelated to the treatment of an Illness or Injury.
- **Wigs** (cranial prostheses) or any treatment for hair loss.
- Services and supplies rendered or provided for **human organ or tissue transplants** other than those specifically named in this PPO booklet.
- **Dental implants** or expenses related to the preparation of the mouth for dental implants.
- **Replacement of teeth** lost as a result of medical condition or treatment.
- **Copayments** for Prescription Drugs.
- **Reversal of voluntary sterilization** procedures.
- **Nutritional** therapy.
- Services rendered by an immediate **family member**.
- **Biofeedback** treatment.
- **Genetic** testing.
- **Gender reassignment** treatment, services or supplies.

- Services or supplies that are **not specifically listed** as Covered Expenses.

XI. PRESCRIPTION DRUG COVERAGE

Prescription drugs are available at a network of retail locations. Maintenance Medications are also available through the Mail Order Prescription Drug Program (as defined below). All drugs must be Medically Necessary and may only be dispensed if the Food and Drug Administration (FDA) has approved the drug for the purpose for which it is dispensed. There is a formulary (a list of preferred drugs). Your cost for obtaining drugs will be less if you use a generic drug. If there is no generic substitute available, a formulary drug will cost you less out of pocket than a non-formulary equivalent.

Prescription Drug Card and Pharmacy Network

Your medical Plan identification card is also your Prescription Drug Program identification card. You can use your card at any pharmacy that is a Participating Pharmacy.

Contact information for the Pharmacy Benefits Manager (PBM) is included in the Important Contact Information portion of this Summary under “Medical Plan Prescriptions.” If you use a pharmacy that is a Participating Pharmacy, the Pharmacy will collect your required Copayment and you will not have to submit a claim. Generally speaking, drugs purchased from a Participating Pharmacy will cost less due to negotiated discounts than drugs purchased from a Pharmacy that is not a Participating Pharmacy. A Participating Pharmacy will submit the claim for you and collect only the required Copayment. On the other hand, if you use a Pharmacy that is not a Participating Pharmacy, you will have to pay the full cost of the drug and submit a claim form to the PBM. In addition, the amount that you pay a Non-Participating Pharmacy for your prescription may be more than the amount that the Plan will reimburse you.

Please remember to present your identification card to the Pharmacy when you fill a prescription at a Participating Pharmacy. The pharmacy can coordinate payment with the Plan’s Pharmacy Benefit Manager only if it has the necessary information included on your card. If you fail to present the card, you may be required to pay the entire, non-discounted cost of the prescription drug, and may not be able to get the benefit of the discount later or otherwise be fully reimbursed. While some pharmacies will allow you to return with your card within a certain number of days (e.g., 7 to 14) after the purchase to prove your eligibility for benefits and then will process the reimbursement on your behalf, not all pharmacies provide such a grace period. Thus, failure to present your card at the time of initial purchase may result in you having to pay the full, non-discounted price for the drug and may reduce your ultimate reimbursement from the Plan.

If you are unable to provide your prescription drug identification card at the point of purchase and it is not already on file, please call the Pharmacy Benefits Manager so that the PBM can supply the necessary information. If you do not remember the phone number, ask the pharmacist to look it up for you. You must make every effort to provide the Pharmacy with the information.

Covered Services

The drugs and supplies for which benefits are available under this benefit Section are:

- Drugs that require, by federal law, a written prescription, including:

- Certain contraceptive medications (generic only);
- Certain smoking cessation medications (generic only);
- Injectable insulin and insulin syringes (mail order only unless specified otherwise); and
- Diabetic supplies, as follows: test strips and lancets (mail order only unless specified otherwise).

Benefits for these drugs and supplies will be provided when:

- A written prescription for them has been issued to a Participant by a Physician; and
- The drugs are purchased from a pharmacy (in person or through the mail).

Copayments for Prescription Drugs

The benefits received and the Copayment amount for drugs will differ depending upon whether they are obtained from a Participating Pharmacy. These amounts also will vary depending upon whether the prescriptions purchased are:

- **Generic Drugs.** A generic drug is a copy of a brand name drug whose patent has expired. The original manufacturer of a drug receives a patent on the drug and is the only manufacturer who can produce and sell the drug during this patent period. Once the patent expires, other manufacturers may produce and sell the drug. These manufacturers usually sell the drug under its common or generic name.
- **Formulary Brand Name Drugs.** A formulary drug is a brand name drug that has been designated as a preferred drug by the Pharmacy Benefits Manager. A brand name drug is a drug that is protected by trademark registration. The current list of formulary medications (also known as The Preferred Drug List) is available on the Web site of the Pharmacy Benefits Manager or by calling the Pharmacy Benefits Manager. The formulary list may change periodically at the discretion of the Pharmacy Benefits Manager. Such changes are made in part to keep current with new drugs as they become available. Participants who have taken a drug in the last 90 days will be notified of changes in the list of formulary drugs. The presence of a drug on the list of formulary medications is not a statement as to its appropriateness or effectiveness in any particular circumstance; the decision as to which drug should be prescribed and dispensed is to be made by the Participant in consultation with his or her medical Provider.
- **Non-Formulary Brand Name Drugs.** A non-formulary drug is a brand name drug that is not on the list of formulary drugs.

For drugs purchased from a Participating Pharmacy, you pay a Copayment amount as follows:

At a Participating Pharmacy: - Retail (Short term medications, Maintenance Medications - less than 4 refills; 34-day supply or 100 units, whichever is less)	Generic: \$10 copay Brand Name (Formulary) \$30 copay* ** Brand Name (Non-Formulary) \$45 copay* **
- Retail (Maintenance Medications – 4th refill and any additional refills ; 34-day supply or 100 units, whichever is less)	Generic: \$20 copay Brand Name (Formulary) \$60 copay* Brand Name (Non-Formulary) \$90 copay*
- Mail Order (Long-term medications for chronic conditions; 90 day supply)	Generic: \$20 copay Brand Name (Formulary) \$60 copay* Brand Name (Non-Formulary) \$100 copay*
*If the member chooses a brand medication when a generic is available, member pays the cost difference between the brand name and the generic drug PLUS the generic copayment.	
**Where there is no direct generic equivalent available, but there are generic or preferred specialty drugs in the same class, the Generic Step Therapy/Specialty Drug Preferred Therapy Program applies. Under this program you may be required to try an available generic or a preferred specialty formulary drug in the same class of drugs; if you do not try the generic or preferred/formulary drug as required, you will pay the full cost of the brand name drug.	

Taking Control of Your Health (“TCOYH”) Diabetes Management Program

If you have diabetes, you may be eligible to participate in the Taking Control of Your Health Diabetes Management Program. Under this program, you may qualify for free medications or reduced Copayments.

Participation is free, voluntary, and strictly confidential. To participate in the Program, call the Program Coordinator as identified in Article V, Important Contact Information. Participation involves regular visits with a certified pharmacist coach. If you comply with the program requirements, you will be eligible for the following benefits and services:

- Free generic diabetes medications and supplies;
- Reduced Copayments for brand diabetes medications and supplies;
- An assigned certified pharmacist coach who will help you understand the disease and manage prescribed medications;
- Up-to-date medical information related to diabetes; and
- Coordination with your Physician.

Generic Step Therapy Program/Specialty Drug Preferred Therapy Program

In many instances there are a number of drugs available to treat a particular Illness or Injury.

- Under the Generic Step Therapy Program, the Plan will require that you first try an available generic medication in the therapeutic class. If you elect to purchase a brand medication without trying an appropriate generic medication, you will pay the full cost of the drug. If you try the generic medication, and your Physician finds that the generic medication is not effective in treating your condition, you will be able to receive the brand medication at the applicable brand Copayment. This does not apply to those brand name prescriptions for which there is a direct generic equivalent available. In those instances, if you decide to take the brand when there is a direct generic equivalent available, you will be required to pay the difference in cost plus the generic Copayment.
- Under the Specialty Drug Preferred Therapy Program, the Plan will require that for certain specialty medications you first try a preferred specialty formulary drug or a generic drug. If you do not try the preferred drug, you will pay the full cost of the drug. If you try the preferred drug, and your Physician finds that the medication is not effective in treating your condition, you will be able to receive the non-preferred formulary drug subject to the applicable Copayment. This does not apply to those brand name prescriptions for which there is a direct generic equivalent available. In those instances, if you decide to take the brand when there is a direct generic equivalent available, you will be required to pay the difference in cost plus the generic Copayment.

The Prescription Benefit Manager will communicate with you and/or your Physician about any drugs that you are taking for which there is an available generic medication or specialty preferred formulary drug that would treat your condition.

Mail Order Prescription Drug Program

For Maintenance Medications (as defined in the Definitions section), you may also use the Mail Order Prescription Drug Program as defined here. The Mail Order Prescription Drug Program allows you to obtain a larger supply of Maintenance Medications than is available at a retail Participating Pharmacy. Also, using mail order often saves you money. For information about this program, contact the PBM. See the Important Contact Information portion of this document for telephone and Internet information for the PBM.

How to Use the Mail Order Feature

If you are taking a Maintenance Medication, ask your Physician to give you a prescription for the Mail Order Prescription Drug Program. Typically, mail order prescriptions are written for up to a 90-day supply of medication. The Mail Order Prescription Drug Program will dispense up to a 90-day supply of most Maintenance Medications. Certain medication will not be sent through the mail (for example, certain narcotic drugs and other medications that cannot be safely sent through the mail). If you order a drug that cannot be shipped or dispensed by the Mail Order Prescription Drug Program, you will be notified by the mail order pharmacy. After your original fill on any single prescription at the Mail Order Prescription Drug Program, you may order refills through the Internet, by telephone, or by mail.

Specialty Prescription Drug Program

Specialty Pharmacy is a unique service model designed to help people manage complex conditions and their associated treatments. Certain chronic and/or genetic conditions require special pharmacy products, often in the form of injected or infused medicines. Medicines handled by the specialty pharmacy may include:

- Injectable or infusions,
- High cost medicines, and
- Medicines that have special delivery or storage requirements (such as refrigeration).

Typically, your Physician, nurse, pharmacy, or other provider will inform you if a prescribed medication must be obtained through the Specialty Pharmacy. Also, if you have questions concerning what medicines are provided by the Specialty Pharmacy under this plan, you may contact the Specialty Pharmacy directly at the telephone number provided in the Important Contact Information section of this document.

Non-Participating Pharmacy Prescriptions

A Non-Participating Pharmacy prescription is a prescription that you obtain from a pharmacy who is not participating in the network (including, for example, a Provider at a Skilled Nursing Facility). You pay the full cost of the prescription and submit a claim form to the pharmacy benefits manager for reimbursement. You must use the claim form provided by the pharmacy benefits manager. Any claim for benefits must include all the required information.

If you obtain prescriptions from a Non-Participating Pharmacy, benefits will be paid at:

- 60% of the Plan's cost for generic drugs and for brand-name drugs when a generic equivalent is not available, and
- 60% of the Plan's generic drug cost if you get a brand-name drug that has a generic equivalent available.

Limits on Prescription Coverage

Payments for Prescription Drug claims are conditioned upon the following:

- The Prescription Drug must be Medically Necessary.
- The Prescription Drug must treat an Illness or Injury.
- The Prescription Drug must be prescribed for a use that the Federal Food and Drug Administration (FDA) has approved for that drug.
- At a retail pharmacy, no more than a 34-day supply or 100 units, whichever is less, may be dispensed in a single fill of a prescription.

- Through the Mail Order Prescription Drug Program, no more than a 90-day supply may be dispensed in a single fill of a prescription.
- Participation in the Generic Step Therapy or Specialty Drug Preferred Therapy Program as described above.
- The Plan Administrator requires Prior Authorization by the Pharmacy Benefits Manager (“the PBM”), Claims Administrator, or the Medical Review Advisor for certain drugs or certain uses. This includes human growth hormone and all specialty drugs available from the Specialty Pharmacy, such as Humira Pen, Gleevec, and Enbrel Sclik. For a list of other drugs or uses for which Prior Authorization is required, contact the PBM.

The Plan Sponsor reserves the right to modify the above list from time to time as new drugs reach the marketplace, or as the FDA approves established drugs to treat other diagnoses, or if it is determined that the drug is being used for off-label, cosmetic or wellness purposes. "Off-label" means that the drug is being used for a purpose not approved by the FDA when it approved the drug for sale in the United States or through subsequent applications by the manufacturer. The dispensing Pharmacy will notify you if a drug is added to this list.

- The Plan Sponsor reserves the right to limit the number of units filled per prescription for certain drugs or for non-daily dosages. For example, benefits for Prescription Drug claims for the one pill per week dosages of Prozac at retail are not available at a rate of 30 units per prescription. Instead, such prescriptions will be available in a one-month's supply at retail, which means that four pills is the quantity limit. The Plan Sponsor reserves the right to determine which drugs will be so limited and to modify at any time such determinations with respect to limits. You will be notified by the dispensing Pharmacy of any applicable limitations.
- Drugs will not be dispensed in amounts in excess of the manufacturer's recommended dosage limits including, but not limited to, length of treatment limits, quantity limits, age limits, gender limits, poly-pharmacy limits or other drug-to-drug interactions that will from time to time be identified by manufacturers.
- Prescription drug data will be retrospectively reviewed to determine if there are any atypical or unusual dispensing patterns. If such patterns or atypical results are identified, the pharmacy benefits manager will notify the dispensing Physician of such activity.
- The Plan will review medical and prescription data from time to time to determine if the prescription drug dispensing activity is within established limits.
- The Copayments for Prescription Drugs do not contribute to any Deductible or out-of-pocket Limit.
- Benefits will not be provided for any refills if the prescription is more than one year old.

XII. PRESCRIPTION DRUG EXCLUSIONS: WHAT'S NOT COVERED BY THE PLAN

No benefits will be paid for claims with respect to the following:

- Drugs prescribed for a use not approved by the FDA.
- Class II narcotics through the Mail Order Prescription Drug Program.
- Retin-A for cosmetic use and for anyone over 25 years of age.
- Botox for cosmetic purposes.
- Any other cosmetic agents.
- Over the counter medications except Insulin, aspirin and folic acid if prescribed by a Physician.
- Prescription medications that are available in a non-prescription strength that is medically effective.
- Anabolic steroids.
- Prescriptions and/or uses that are not Medically Necessary.
- Brand name contraceptives (unless there is no generic available or the generic is medically inappropriate).
- Brand name smoking cessation drugs (unless there is no generic available or the generic is medically inappropriate).
- Non- prescription drugs and vitamins.
- Immunizations and inoculations.
- Drugs that are considered Experimental by generally accepted medical practice standards.
- Drugs for smoking cessation without prescriptions.
- Drugs for weight loss.
- Drugs for which there is no charge.
- Nutritional supplements.
- Prescription vitamins, except for prescription strength calcium, potaba, mephyton, and folic acid.

Additionally, see the “Medical Plan Exclusions: What’s Not Covered by the Plan” section (beginning on page 59) for general exclusions regarding benefits as they also apply to the Prescription Drug program.

XIII. CLAIM FILING PROCEDURES

**Throughout this section "you" and "your" refers to any Participant filing a claim, and "Claims Administrator" refers to the applicable Plan vendor that has been delegated the responsibility by the Plan Administrator for reviewing and determining certain initial claims.*

Claim Filing

To file a claim under this Plan, you must show the appropriate identification card to the Hospital, Doctor, or other Provider when services are received. Normally, the Provider will send the bill to the applicable Claims Administrator directly on your behalf. However, it is your responsibility to ensure that the necessary claim information has been provided to the applicable Claims Administrator.

The following chart lists the Claims Administrators for the Plan. You may obtain detailed contact information for the Claims Administrators by reviewing the Important Contact Information section of this booklet.

Type of Claim	Applicable Claims Administrator
1. Medical services which you received under the Plan that do not require Pre-Certification or already have been Pre-Certified.	Medical Claims Administrator: Blue Cross and Blue Shield of Illinois www.bcbsil.com
2. Request for Pre-Certification of medical benefits (not drugs) as required under the Plan.	Medical Plan Advisor: Telligen (formerly Encompass) https://telligen.qualitrac.com
3. Claims related to retail, specialty and mail order prescription drug benefits (including requests for Prior Authorization).	Prescription Benefit Manager: CVS Caremark www.caremark.com
4. Claims involving questions related to eligibility.	Benefits Service Center www.cityofchicagobenefits.org
5.	

For services requiring Pre-Certification, you must contact the Medical Plan Advisor within the timeframes set forth in Article VII and provide the information listed for the applicable service set forth in Article VII. For prescription drug benefits requiring Prior Authorization, you must contact the Prescription Benefit Manager.

If you pay for a service up front, you then will have to file a claim with the applicable Claims Administrator. For example, if you paid your doctor's office for medical benefits you will have to send your claim to the Medical Claims Administrator. Likewise, if you pay for a prescription drug in full at the pharmacy, you then will have to send a claim to the Prescription Benefit Manager. However, most PPO Providers (including Participating Pharmacies) will file

your claim directly with the applicable Claims Administrator on your behalf. You will be responsible, however, for filing any claims that are not filed directly by the provider (for example, most Non-PPO Providers do not file claims with the Plan's Claims Administrators).

When sending bills for processing, you will need to complete a claim form, making sure to include:

- The name of the patient;
- The name and Unique Identification Number of the Employee;
- The date and charge for each service rendered;
- The diagnosis, type of Illness, or Injury for each charge;
- The description or type of service or treatment provided; and
- The name, address, phone number, and tax identification number of the Provider.

Except for services requiring Pre-Certification or Prior Authorization, claims should be mailed to the applicable Claims Administrator at the address indicated in the "Important Contact Information" section. For services requiring Pre-Certification, simply call the Medical Plan Advisor before you have the services. For prescription drug benefits requiring Prior Authorization, simply call the Prescription Benefit Manager before you purchase the drug.

An urgent care claim for benefits may be submitted to the applicable Claims Administrator by telephone or by fax. The claim should include at least the following information:

- The name/identity of the claimant/patient,
- The specific medical condition or symptom, and
- A specific treatment, service or product for which approval or payment is requested.

Eligibility & Enrollment Inquiries

If you have a question regarding initial Plan eligibility and enrollment, you should contact the Benefits Service Center. When making an eligibility inquiry to the Benefits Service Center, you will need to provide sufficient information and details relating to your question so that the Benefits Service Center will be able to respond to your inquiry in a timely manner. An inquiry regarding initial Plan eligibility or enrollment alone (without an actual claim for payment for services under the Plan) is not considered a "claim" within the meaning of this Plan and thus is not subject to many of the procedural requirements applicable to claims. Nonetheless, the Benefits Service Center will give all such inquiries due consideration and attempt to address them in a timely fashion. Additionally, the Plan does provide for review of such determinations, as set forth in the subsection "Disputes Involving Initial Plan Eligibility" in the following Article XIV, entitled "Claim And Appeal Determination Procedures."

Providing Notices

Any information or notice that must be furnished to a Claims Administrator under the Plan as described in this booklet must be in writing and sent to the applicable Claims Administrator at the address indicated in the Important Contact Information section. For Pre-Certification or Prior Authorization requests, however, you, or your Provider on your behalf, may contact the Medical Plan Advisor or the Prescription Benefit Manager by phone in order to provide any requested information within the applicable timeframes as described in the “Medical Advisor Review Program” or elsewhere in this document.

Time Limits for Filing Claims

Claims, other than pre-service claims (i.e., claims involving requests for Pre-Certification or Prior Authorization), must be submitted to the applicable Claims Administrator for processing within two years of the date the service is rendered. Do not send medical or prescription drug claims to the Benefits Service Center or the Medical Plan Advisor.

Claims involving requests for Pre-Certification for medical services must be submitted within the timeframes set forth in Article VII. Claims for Prior Authorization of certain prescription drugs must be submitted pursuant to Article XI.

Payment of Claims and Assignment of Benefits

The Plan has delegated to the applicable Claims Administrator the responsibility for the initial benefit determination and for reviewing and deciding certain appeals. The following Article entitled “*Claim and Appeal Determination Procedures*” provides additional information regarding the Plan’s procedures for deciding claims and appeals.

Under this Plan, the applicable Claims Administrator has the right, in its sole discretion, to make any benefit payment either to the Participant or directly to the Provider. For example, the Claims Administrator may pay benefits to you if your Covered Expenses are incurred as a result of treatment by a Non-PPO Provider. The Claims Administrator is specifically authorized by you to determine to whom any benefit payment should be made. Once you receive covered services from a Provider, the applicable Claims Administrator will pay the claim based on the provisions of the Plan. You have no right to request that the Claims Administrator not pay the claim, and any such request will be ignored. The Claims Administrator will not be liable to you or any other person based on the rejection of such a request.

You may not assign or transfer, in whole or in part, to any person or entity, including any Provider, your claim for Plan benefits at any time before or after Covered Expenses are incurred. Any such attempted assignment or transfer of a claim for benefits or coverage is null and void.

Provider Relationships

The choice of a Provider is solely your choice, and neither the Claims Administrator nor the City will interfere with your relationship with any Provider.

Neither the City nor the applicable Claims Administrator itself undertakes to furnish health care services, but solely to make payments to Providers for Covered Expenses. Neither

the applicable Claims Administrator nor the City are liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services. Professional medical services that can be legally performed only by a Provider are not provided by the Claims Administrator or the City. The applicable Claims Administrator may have a contractual relationship with a Provider, but this should not be construed to mean that the applicable Claims Administrator is providing professional services.

The Plan may describe a Provider as “participating,” “professional,” “preferred,” or “network,” but this should not be construed as a recommendation, referral, or any other statement as to the ability or quality of the Provider. Likewise, the omission or non-use of these terms or the use of terms such as “non-participating,” should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of the Provider.

Information and Records

It is your responsibility to make sure that any Provider, other plan, insurance company, employee benefit association, government body or program, or any other person or entity having knowledge of or records (such as a medical history) or any information relating to any Illness or Injury for which a claim is made under the Plan, , furnishes or otherwise takes steps to make available (such as by signing any necessary authorization forms) to the applicable Claims Administrator or its agent, any and all such information and records, at any time upon the Claims Administrator’s request.

In addition, the applicable Claims Administrator may furnish similar information and records (or copies of records), in accordance with HIPAA (see Article XIX), to Providers, insurance companies, governmental bodies or programs, or other entities providing insurance-type benefits requesting the same. It is also your responsibility to provide the Claims Administrator and/or the Benefits Service Center information regarding eligibility for Medicare so that the applicable Claims Administrator may be able to make claim payments in accordance with applicable laws.

XIV. CLAIM AND APPEAL DETERMINATION PROCEDURES

**Throughout this section "you" and "your" refers to any claimant (defined below) and "Claims Administrator" refers to the applicable Plan vendor that has been delegated the responsibility by the Plan Administrator for reviewing and determining claims and appeals.*

The procedures set forth in this Article XIV apply to claims and appeals related to services received on or after January 1, 2013.

Definitions

“Adverse Benefit Determination” means a decision that is “adverse” because it is (i) a denial, reduction, or termination of a benefit, or (ii) a failure to provide or make payment (in whole or in part) for a benefit. An adverse benefit determination may include:

- A determination to retroactively terminate a claimant’s Plan coverage;
- A determination of ineligibility related to a claim for benefits;
- A determination that a benefit is not a covered benefit; or
- A determination that a benefit is Experimental and/or Investigative, or not Medically Necessary.

“Authorized representative” means someone who is authorized by the claimant to act on behalf of the claimant with respect to a benefit claim or appeal under these procedures.

“Claim” means any request for a Plan benefit made in accordance with the Plan’s claims procedures. Simple inquiries about eligibility or the Plan’s provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits. In addition, a request for Pre-Certification, Prior Authorization, or pre-determination of, or an inquiry about a benefit that does not require Pre-Certification or Prior Authorization by the Plan will not be treated as a claim for benefits.

“Claimant” means someone (including your authorized representative) who makes a request for a Plan benefit(s) in accordance with the Plan’s claims procedures.

“Day” means a calendar day.

“Final Internal Adverse Benefit Determination” means a decision on appeal if it upholds in whole or part an adverse benefit determination after the conclusion of the Plan’s internal claims appeals process has been exhausted.

Types of Health Care Claims

Generally, there are four types of health care claims which include all claims for medical and prescription drug benefits. The claim type is determined initially when the claim is filed. However, if the nature of the claim changes as it proceeds through these claims procedures, the claim may be re-characterized. For example, a claim initially may be an urgent care claim. If the urgency subsides, it may be re-characterized as a post-service claim.

Please note that questions involving initial eligibility are administered by the Benefits Service Center and, as stated previously, are not considered “claims,” and thus are not subject to many of the rules set forth in this Article XIV. Nonetheless, the Plan does provide a process for review of any disputes related to eligibility determinations as discussed in further detail below in the sub-section entitled “Disputes Involving Initial Plan Eligibility.” However, if an actual claim for benefits arises involving issues of Plan eligibility, then the claim will be handled according to the procedures contained in this Article, just like any claim. Such claims may first be administered by a Claims Administrator other than the Benefits Service Center. However, if the applicable Claims Administrator is unable to resolve the eligibility issue, the Benefits Service Center will administer the eligibility aspect of the claim.

- **Pre-Service Claims:** A claim is a pre-service claim if you are required to obtain Pre-Certification or Prior Authorization before receiving medical or prescription drug benefits under the Plan -- unless the claim involves urgent care, as defined below. Benefits under this Plan that require Pre-Certification are listed in Article VII and information on the drug benefits that require Prior Authorization may be found in Article XI.
- **Urgent Care Claims:** An urgent care claim is any claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to non-urgent care claims could seriously jeopardize the claimant’s life or health or ability to regain maximum function, or would, in the opinion of the treating Physician, subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

On receipt of a pre-service claim, the applicable Claims Administrator will make a determination of whether it involves urgent care, provided that, if a Physician with knowledge of the claimant's medical condition determines that a claim involves urgent care, the claim will be treated as an urgent care claim.

- **Concurrent Care Claim.** A concurrent care decision occurs when the Plan approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims: (a) claims where reconsideration of the approval results in a reduction or termination of the initially-approved period of time or number of treatments; and (b) claims where an extension is requested beyond the initially-approved period of time or number of treatments.
- **Post-Service Claim.** A post-service claim is any other claim for a benefit under this Plan that is not a pre-service, urgent care, or concurrent care claim.

It is very important to follow the requirements that apply to your particular type of claim. If you have any questions regarding what type of claim and/or what claims procedure to follow, contact the Benefits Service Center by calling the number in the “Important Contact Information” section of this booklet.

Timeframes for Initial Benefit Claim Determinations

- Pre-Service Claims (including all Plan services requiring Pre-Certification or Prior Authorization). An initial pre-service claim will be decided within 15 days after receipt of the claim (sooner if reasonable).
- Urgent Care Claims. The applicable Claims Administrator will decide an initial urgent care claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim.
- Concurrent Care Extension Claims. If a claim involves a request to extend a concurrent care decision (defined above) involving urgent care and if the claim is made at least 24 hours prior to the end of the initially-approved period of time or number of treatments, the claim will be decided no more than 24 hours after receipt of the claim. Any other request to extend a concurrent care decision will be decided in the otherwise applicable timeframes for pre-service or post-service claims.
- Concurrent Care Early Termination Claims. A decision by the applicable Claims Administrator to reduce or terminate an initially-approved course of treatment shall be provided sufficiently in advance of the reduction or termination to allow the claimant to appeal the adverse benefit determination and receive a decision on review under these procedures prior to the reduction or termination.
- Post-Service Claims. An initial post-service claim will be decided within 30 days after receipt of the claim (sooner if reasonable).

Despite the specified timeframes, nothing prevents a claimant from voluntarily agreeing to extend the above timeframes. In addition, if the applicable Claims Administrator is not able to decide a pre-service or post-service claim within the above timeframes, due to matters beyond its control, one 15-day extension of the applicable timeframe is permitted, provided that the claimant is notified in writing prior to the expiration of the initial timeframe applicable to the claim. If any information needed to process a claim is missing, the claim shall be treated as an incomplete claim.

If you make a request for Pre-Certification or Prior Authorization that does not comply with the Plan's procedures for making Pre-Certification and Prior Authorization requests as set forth in Articles VII and XI, respectively, the applicable Claims Administrator will notify you of the failure and of the proper procedure as soon as appropriate, but not later than 5 days (24 hours in the case of a claim involving urgent care) following discovery of the failure. Such notification may be provided orally unless you request a written notice.

If an urgent care claim is incomplete, the applicable Claims Administrator will notify the claimant as soon as possible, but no later than 24 hours following receipt of the incomplete claim. The notification may be made orally to the claimant, unless the claimant requests written notice, and it will describe the information necessary to complete the claim and will specify a reasonable time of no less than 48 hours, within which the claim must be completed. The applicable Claims Administrator will decide the claim as soon as possible but not later than 48

hours after the earlier of (a) receipt of the specified information, or (b) the end of the period of time provided to submit the specified information.

If any other type of claim is incomplete, the applicable Claims Administrator may deny the claim or may take an extension of time, as described above. If the Claims Administrator takes an extension of time, the extension notice shall include a description of the missing information and shall specify a timeframe of no less than 45 days in which the necessary information must be provided. The timeframe for deciding the claim will be suspended from the date the extension notice is received by the claimant until the date the missing necessary information is provided to the Plan. If the requested information is provided, the Claims Administrator will decide the claim within the extended period specified in the extension notice. If the requested information is not provided within the time specified, the claim may be decided without that information.

Notification of Initial Benefit Claim Determination

Written notification of the Claims Administrator's decision will be provided to the claimant whether or not the decision is adverse. Notification of an adverse benefit determination of an urgent care claim may be provided orally, but written notification will be furnished not later than 72 hours after the oral notice. Notification of an adverse benefit determination will include the following:

- Information sufficient to identify the claim involved, including the date of the service, the health care provider, and the claim amount (if applicable), (the applicable diagnosis code and/or treatment code and its corresponding meaning, will only be provided upon written request).
- A statement of the specific reason(s) for the adverse benefit determination, including, but not limited to the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, used in denying the claim.
- Reference(s) to the specific Plan provision(s) on which the decision is based.
- A description of any additional information necessary to complete the claim and why such information is necessary.
- A description of available internal appeals and external review processes.
- A description of the Plan procedures and time limits to appeal the decision, and the right to obtain information about those procedures.
- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request).
- If the decision involves a claim for benefits relating to Medical Necessity, an explanation as to the criteria for Medical Necessity determinations.

- If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances (or a statement that such explanation will be provided at no charge upon request).
- In the case of an urgent care claim, an explanation of the expedited review methods available for such claims and the contact information for the relevant office of health insurance consumer assistance (if available).

Your Right to Appeal an Internal Adverse Benefit Determination

A claimant has a right to appeal an adverse benefit determination. The appeal process shall include a full and fair review which features the following:

- A right to present testimony and submit other evidence or other information in support of the appeal.
- A right to request, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.
- A review that will consider all information timely submitted by the claimant, whether or not presented or available at the initial benefit decision.
- A review where the person(s) who reviews and decides the appeal at each level of appeal will be a different individual than the person who made the initial adverse benefit determination and will not be a subordinate of the person who made the initial adverse benefit determination. No weight will be given to the initial adverse benefit determination.
- In the case of a claim denied on the grounds of a medical judgment, a health professional with appropriate training and experience will be consulted. The health care professional who is consulted on appeal will not be the same individual who was consulted, if any, regarding the initial benefit decision or a subordinate of that individual.
- If the advice of a medical or vocational expert was obtained in connection with the initial benefit decision, the names of each such expert shall be provided on request by the claimant, regardless of whether the advice was relied on by the Claims Administrator. Additionally, a claimant will be given reasonable access to, and copies of any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage. Such claimant also will be provided a reasonable opportunity to respond to any new evidence or rationale.
- All necessary information in connection with an urgent care appeal will be transmitted between the Claims Administrator and the claimant by telephone or facsimile.

How to Appeal an Internal Adverse Benefit Determination

All claims for benefits under the Plan require an internal level of appeal before claimants may apply for external review. Claims for prescription benefit services require two levels of internal appeal. Additionally, a claimant may voluntarily appeal to the Benefits Committee any decision made on internal appeal except decisions involving a determination of Medical Necessity or medical judgment. If you wish to appeal a decision by the Benefit Service Center involving a determination of initial eligibility, please see the subsection in this Article XIV entitled "Disputes Involving Initial Plan Eligibility" for additional information.

A claimant must exhaust all applicable internal levels of appeal before filing a lawsuit with respect to any claim. Any legal action challenging the decision of the applicable Claims Administrator or the Benefits Committee must be brought within one year from the date of notice of the final adverse benefit determination. Additionally, if a claimant fails to include any theories or facts in his written appeal, such facts or theories will be deemed waived and may not be raised in a subsequent legal action.

An appeal of an initial adverse benefit decision of any claim must be made by the claimant (or authorized representative) to the applicable Claims Administrator using the forms (if any) provided by the applicable Claims Administrator. The appeal must be made within 180 days following the claimant's receipt of the initial notification of the adverse benefit decision, except that the appeal of a decision by the Claims Administrator to reduce or terminate an initially-approved course of treatment (see the definition of concurrent care claim) must be filed within 30 days of the claimant's receipt of the notification of the applicable Claims Administrator's decision to reduce or terminate. Failure to comply with this important deadline may cause the claimant to forfeit any right to further review of an adverse benefit determination under these procedures or in a court of law.

An urgent care appeal may be submitted by telephone or fax to the applicable Claims Administrator. The appeal should include at least the following information:

- The name/identity of the claimant/patient;
- A specific medical condition or symptom;
- The specific treatment, service or product for which approval or payment is requested; and
- Any reasons why the appeal should be processed on a more expedited basis.

If the claimant's initial appeal for prescription drug benefits is denied, the claimant may request a second appeal of the decision by appealing in writing to the Prescription Benefit Manager using the forms (if any) provided by the Prescription Benefit Manager. The second appeal must be made within 180 days following the claimant's receipt of the notification of the initial appeal decision. Failure to comply with this important deadline may cause the claimant to forfeit any right to further review of an adverse benefit determination under these procedures or in a court of law. All required levels of internal appeal must be exhausted before external review applies.

- *Voluntary Appeal to the Benefits Committee of an Adverse Internal Appeal Decision*

If a claim or a portion of a claim does not involve a determination of Medical Necessity or medical judgment and it is denied upon appeal, the claimant voluntarily may appeal the decision a second time (free of charge) to the City's Benefits Committee by filing a written appeal to the following address within 60 days of the date of the applicable Claims Administrator's initial decision upon appeal.

The Benefits Committee
c/o Benefits Management Division
333 S. State Street, Room 400
Chicago, Illinois 60604-3978

The appeal should include a brief statement of the reason you believe the denial is wrong. It should also include any additional information that would help the Benefits Committee in reviewing the claim appeal. **You may appeal to the Benefits Committee only after you have exhausted your right to appeal to the applicable Claims Administrator.**

NOTE: You may skip this voluntary level of appeal. If you do appeal to the Benefits Committee, any statute of limitations is extended while this voluntary level of appeal is pending. Your decision as to whether to submit a benefit dispute to the Benefits Committee will have no effect on your rights to any other benefits under the Plan. A claimant who requests an appeal under this voluntary level of appeal may request information about the voluntary appeal process, including information related to your right to representation, the process for selecting the Benefits Committee members, and the circumstances, if any, that may affect the impartiality of the Benefits Committee members.

Discretion of the Benefits Committee and the Applicable Claims Administrator

The Benefits Committee has complete discretion to interpret the terms of the Plan, and no benefits will be paid unless the Benefits Committee or its authorized representative (i.e., the applicable Claims Administrator) has determined in its sole discretion that a claimant is entitled to them.

Timeframes for Decisions on Internal Appeal (Excluding Voluntary Appeals to the Benefits Committee)

- **Pre-Service Claims.** The appeal will be decided by the applicable Claims Administrator within 30 days after its receipt of the request for review (or sooner if reasonable). An appeal of a pre-service request for Pre-Certification or Prior Authorization will be decided by the applicable Claims Administrator within 15 days after its receipt of the request for review.
- **Urgent Care Claims.** The appeal of an urgent care claim will be decided as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt by the applicable Claims Administrator of the request for review.

- **Post-Service Claims.** The appeal generally will be decided by the applicable Claim Administrator within 60 days after its receipt of the request for review. However, an appeal of a post-service claim for prescription drug benefits or a post-service review by the Medical Plan Advisor will be decided by the Prescription Benefit Manager or the Medical Plan Advisor, respectively, within 30 days after receipt of the request for review.
- **Concurrent Care Claims.** If the appeal is filed sufficiently in advance, the appeal of a decision by the applicable Claim Administrator to reduce or terminate an initially-approved course of treatment (see the definition of concurrent care claim) shall be decided before the proposed reduction or termination takes place. The appeal of a denied request to extend concurrent care decision shall be decided in the appeal timeframe for pre-service, urgent care, or post-service claims described above, as appropriate to the request.

Notification of Final Decision on Internal Appeal

Written notification of the final decision on appeal will be provided to the claimant whether or not the decision is adverse. Written notification of a final internal adverse benefit determination on appeal will include the following information (if applicable):

- Information sufficient to identify the claim involved, including the date of the service, the health care provider, and the claim amount (if applicable);
- The specific reason(s) for the final internal adverse determination including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim and a discussion of the decision;
- A description of available internal appeals (if any) and external review processes, including information regarding how to initiate an appeal;
- A reference to the specific Plan provision(s) on which the decision is based;
- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request);
- A statement indicating entitlement to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination;
- If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances (or a statement that such explanation will be provided at no charge upon request); and
- The contact information for the relevant office of health insurance consumer assistance (if available).

Notification of a final internal adverse benefit determination on appeal of an urgent care claim may be provided orally, but written notification will be furnished not later than three days after the oral notice.

If the Plan fails to strictly adhere to the above claims appeal procedures, a claimant will be deemed to have exhausted the Plan's internal claims appeal process and may initiate any available external review process (described below) or other available legal remedies. Notwithstanding the previous sentence, if the violation of these procedures was (1) minor, (2) non-prejudicial, (3) due to errors attributable to good cause or outside the Plan Administrator's (or applicable Claim Administrator's) control, (4) in the context of a good faith exchange of information, and (5) not reflective of a pattern of noncompliance, a claimant is obligated to exhaust the above internal claims and appeal procedures before initiating external review or filing suit.

External Review Procedures

Following a final decision on internal appeal, a claimant may file a request for an external review of the denied claim if the claimant received a final adverse benefit determination on an internal appeal involving a medical judgment (i.e., determinations of whether a treatment is Medically Necessary or Experimental or Investigational and evaluations of level of care, appropriateness, health care setting or effectiveness of a covered benefit) or a rescission of benefits (i.e., a retroactive termination of benefit coverage).

External review is conducted by an independent review organization (an "IRO"). This is an organization that is completely separate from and independent of the Plan and the Claims Administrators responsible for deciding claims and internal appeals.

Expedited external review procedures exist for claims involving urgent care. Please review the following subsection entitled "Expedited External Claim Review Procedures."

Requests for an external review must be filed with the applicable Claims Administrator by the first day of the fifth month following the receipt of the notice of an adverse benefit determination or final adverse benefit determination. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday.

Within five business days following the date of receipt of the external review request, the applicable Claims Administrator will complete a preliminary review of the request to determine whether external review is available. Specifically, the applicable Claims Administrator will consider whether:

- The claimant is or was covered under the Plan at the time the health care item or service was requested;
- The adverse benefit determination involves a medical judgment or a rescission (termination of coverage) or relates to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (eligibility determinations are not entitled to external review);

- The claimant has exhausted the Plan's internal appeal process; and
- The claimant has provided all the information required to process an external review.

Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant (or the claimant's authorized representative) advising as to whether external review is available.

If the request is complete but the claim is not eligible for external review, such notification will include the reasons why and contact information for the Employee Benefits Security Administration. If the request is not complete, such notification will describe the information or materials needed to make the request complete, and the claimant will have the right to complete the request for external review within the initial filing period for external review or within the 48-hour period following receipt of the notification, whichever is later.

The external review by the IRO shall consist of the following:

- Within five business days after the assignment of the IRO, the applicable Claims Administrator will provide the IRO the documents and information that had been considered in making the adverse benefit determination. (The IRO may reverse the adverse benefit determination if the Claims Administrator fails to provide these materials.)
- The IRO will provide the claimant timely notice of its acceptance of the claim for external review. Within ten business days of the receipt of this notice, the claimant may submit additional written evidence, which the IRO *must* consider. The IRO *may* consider evidence submitted after ten business days.
- Within one business day of receipt of information from the claimant, the IRO must forward this information to the applicable Claims Administrator, which may reconsider its adverse benefit determination.

The IRO must provide to the claimant and the Plan written notice of its decision within 45 days after the IRO receives the request for the external review.

After a final external review decision (or final expedited external review decision), the IRO will maintain for six years the records of all claims and notices associated with the external review process. Such records will be available for examination, upon request by the claimant, the Plan, or a state or federal oversight agency (unless such disclosure would violate state or federal privacy laws).

Upon the applicable Claims Administrator's receipt of a final external review decision (or final expedited external review decision) reversing the adverse benefit determination, the Plan immediately will provide coverage or payment for the claim.

Expedited External Claim Review Procedures

A claimant may request an expedited external review at the time the claimant receives an adverse benefit determination, if:

- The adverse benefit determination involves a medical condition with respect to which the time frame for completion of an expedited internal appeal would seriously jeopardize the claimant's life or health or ability to regain maximum function, and
- The claimant has filed a request for an expedited internal appeal.

A preliminary review (as provided above with respect to a standard external review) will be conducted immediately upon receipt of the request for expedited external review. Immediately following a preliminary review of the request for an expedited external review, the Plan will issue a notification in writing to the claimant (or the claimant's authorized representative) as to whether an expedited external review is available.

If the request is complete but the claim is not eligible for external review, such notification must include the reasons why and contact information for the Employee Benefits Security Administration. If the request is complete and the claim is eligible for a standard external review, but not an expedited review, the procedures for a standard external review (described above) shall apply. If the request is not complete, such notification must describe the information or materials needed to make the request complete, and the claimant will have the right to complete the request.

Upon a determination that a request is eligible for expedited external review following the preliminary review, the Plan will assign an IRO under the procedures for a standard external review (described above). The Plan will provide the IRO electronically, by telephone or facsimile, or by any other available expeditious method, all necessary documents and information considered in making the adverse benefit determination.

The review of the IRO shall consist of providing a notice of the final external review decision, in accordance with the requirements for a standard external review and resulting decision (described above), as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice of the decision is not initially provided in writing, then within 48 hours after the date of providing the notice, the IRO must provide written confirmation of the decision to the claimant and the Plan.

Disputes Involving Initial Plan Eligibility or Increased Health Care Contributions

If you dispute a response provided by the Benefits Service Center to your question regarding initial Plan eligibility and enrollment, you have the right to request a review of the decision by sending a written request to the attention of the Benefits Service Center at the address listed in the "Important Contact Information" section of this booklet within 60 days after notification of the adverse decision by the Benefits Service Center. Likewise, if you dispute a decision by the Plan that you have not met the participation requirements of the Chicago Lives Healthy Wellness Program and thus are required to pay an increased health care contribution, you also have the same right to review.

If the Benefits Service Center determines that you are not eligible to participate in the Plan or that you have not met the Wellness Program participation requirements, you will be notified of the determination. A written notice will be provided and will include the reason for the determination and a statement of your right to appeal the determination to the Benefits Committee.

You may then appeal the denial by submitting a written request to the Benefits Committee no later than 30 days after the notice of denial by the Benefits Service Center. The written appeal should be sent to:

The Benefits Committee
c/o Benefits Management Division
333 S. State Street, Room 400
Chicago, Illinois 60604-3978

The appeal should include a brief statement of the reason you believe the determination is wrong. It should also include any additional information that would help the Benefits Committee in reviewing the appeal. In addition, you may request to appear at a Benefits Committee meeting (such request to be granted at the Benefits Committee's sole discretion). The Benefits Committee will review the appeal and a determination will be made within 60 days of reviewing the appeal. The Benefits Committee will send a notice of its decision on the appeal.

The appeals process described above (including appeals to the Benefits Committee) must be exhausted before, and as a condition precedent to, any further attempts at redress in any forum. Any legal action challenging the decision of the Benefits Committee must be brought within one year from the date of notice of the Benefits Committee's decision. Additionally, if a claimant fails to include any theories or facts in his written appeal to the Benefits Committee, they will be deemed waived and may not be raised in a subsequent legal action. Appeals involving initial Plan eligibility determinations or increased health care contributions are not eligible for external review.

XV. COORDINATION OF PLAN BENEFITS WITH MEDICARE FOR MEDICARE ELIGIBLE PARTICIPANTS

A series of federal laws collectively referred to as the Medicare Secondary Payer (MSP) laws regulate the manner in which employers may offer group health care coverage to Medicare eligible Employees, Spouses, and in some cases, Dependent children.

To assist the City in complying with the MSP laws, it is very important that a Participant promptly and accurately complete any requests for information from the Benefits Management Division or Benefits Service Center regarding the Participant's Medicare eligibility. In addition, if you or any of your covered Dependents becomes eligible for Medicare, or has Medicare eligibility terminated or changed, please contact the Benefits Service Center to ensure that our records accurately reflect the correct Medicare status of the covered individual.

If you or any of your covered dependents is eligible for Medicare due to End Stage Renal Disease (ESRD), the Benefits Service Center needs to know the date of Medicare eligibility and any changes in Medicare eligibility. The Claims Administrator will keep track of the 30-month period during which the City's Plan is primary.

The statutory requirements and rules for Medicare Secondary Payer coverage may vary depending on the basis for Medicare and employer group health plan coverage. (Medicare Secondary Payer rules may not apply, however, with respect to coverage for Domestic Partners and Civil Union Spouses.)

In general, the Plan will adhere to the following rules:

- If a Participant has End Stage Renal Disease (ESRD), Medicare pays secondary during the first 30 months of coverage and primary thereafter.
- If Plan coverage is due to the Employee's **current employment status** and Medicare entitlement is due to age (i.e., attaining age 65), Medicare pays secondary to the Plan. If a Participant wants to have Medicare pay primary, the City cannot offer secondary coverage.
- If a Dependent is also working and is covered by other insurance, that plan would be the primary plan for the Dependent, this Plan would coordinate with the primary plan, and Medicare would pay only after the combined payments of the two other plans.
- In the case of disabled individuals under 65, Medicare is secondary if the Participant is covered under a health care plan due to **current employment status**. In most instances if a Participant wants to have Medicare pay as primary, the City cannot offer secondary coverage.
- Notwithstanding the above, if a former Employee is retired and remains in this Plan as a result of a collective bargaining agreement, Medicare is primary for the Medicare-eligible retiree, Spouse or Dependent child because of the retirement status of the former Employee. Furthermore, if a retiree covered under this Plan is eligible for Medicare, his or her benefits under this Plan will be paid as if

she/he were enrolled in Medicare Parts A & B, regardless of whether she/he actually is.

If a Participant who is not retired wants to have Medicare as primary health coverage when Medicare otherwise would be secondary as set forth above, the Participant must notify the City, and the City will cancel the Participant's coverage.

XVI. COORDINATION OF BENEFITS

Many individuals have medical coverage in addition to this Plan. For example, you may be covered as a dependent under your spouse's plan. The Plan works with other group plans to reimburse up to 100% of the allowable expense of health care services for you and your Dependents. An allowable expense is any expense covered at least in part by this Plan. The maximum amount payable by this Plan is limited to the amount that would have been paid if there were no other plans involved. You are required to notify the City upon initial enrollment in this Plan if you or any of your Dependents are covered by any other health benefit plan. The Claims Administrator may send you a coordination of benefits questionnaire form. This questionnaire must be completed and returned. Claims will not be processed until the completed questionnaire has been returned.

The following types of other plans will be coordinated with the City's Plans. "Other plan" means any plan providing benefits or services for or because of health care or treatment, which benefits or services are provided by but not limited to:

- No-fault automobile insurance plans;
- Other group health care plans or plans covering individuals as members of a group;
- Group Hospital service prepayment plans; group medical service prepayment plans, group practice or other group prepayment coverage; and
- Government programs including Medicare.

How Coordination of Benefits Works

To coordinate benefits, it is necessary to determine what the payment responsibility is for each benefit program. The order of benefit determination rules determine whether this Plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this Plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this Plan is secondary, it determines benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100% of the total allowable expense.

Allowable expense means any Usual and Customary Charge that you are legally required to pay, including Deductibles, Coinsurance, and Copayments, that is covered at least in part by any plan covering you. When an "other plan" provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any other plan covering the person is not an allowable expense. In no event, however, will allowable expenses include expenses for services received because of any Injury arising out of or in the course of any employment (including self-employment) for wage or profit or any sickness entitling the person for whom a claim is made to benefits under any workers' compensation, duty disability, or occupational disease law.

Examples of expenses that are not allowable expenses include:

- The difference between the cost of a semi-private Hospital room and a private Hospital room is not an allowable expense unless one of the plans provides coverage for private Hospital room expenses.
- Any amount in excess of the maximum allowable amount.
- The amount of any benefit reduction by the primary plan because you failed to comply with plan provisions, such as Pre-Certification of Hospital admissions or other treatment or services and participating provider arrangements.

Claim determination period means a period beginning with any January 1 and ending with the next following December 31 except that the first claim determination period with respect to any person begins on the effective date of coverage under the Plan and ends on the next following December 31. In no event will a claim determination period extend beyond the last day on which a person is covered under the Plan.

Order of Benefit Determination Rules

When you are covered by two or more plans, the rules for determining the order of benefit payments are as follows:

- The primary plan pays or provides benefits according to its terms of coverage and without regard to the benefits of any other plan.
- A plan that does not contain a coordination of benefits provision is primary.

Each plan determines its order of benefit determination using the first of the following rules that apply:

- **Non-dependent or dependent.** The plan that covers the person other than as a dependent, for example as an Employee, member, policyholder, subscriber, or retiree is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the dependent person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g. a retired Employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an Employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan.
- **Dependent child covered under more than one plan.** Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one plan the order of benefits is determined as follows:
 - For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
 - The plan of the parent whose birthday falls earlier in the Calendar Year is the primary plan; or

- If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
- For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - If a court decree or a ruling or order of an administrative tribunal with appropriate jurisdiction states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to Plan Years beginning after the Plan is given notice of the court decree;
 - If a court decree or administrative ruling or order states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of the birthday rule above will determine the order of benefits;
 - If a court decree or administrative ruling or order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of the birthday rule above will determine the order of benefits; or
 - If there is no court decree or administrative ruling or order allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - ✓ The plan covering the custodial parent. The custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the Calendar Year excluding any temporary visitation;
 - ✓ The plan covering the spouse of the custodial parent;
 - ✓ The plan covering the non-custodial parent; then
 - ✓ The plan covering the spouse of the non-custodial parent.
 - For a Dependent child covered under more than one plan of individuals who are the parents of the child, the provisions above will determine the order of benefits as if those individuals were the parents of the child.
- **Active employee or terminated, retired, or laid-off employee.** The plan that covers a person as an active employee (an employee who is not terminated, laid

off, or retired) is the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.

- **PHSA COBRA, or state or other federal continuation coverage.** If a person whose coverage is provided pursuant to PHSA COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the primary plan and the PHSA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.
- **Full-time or part-time.** The plan that covers the person as a full-time employee or as a Dependent of a full-time employee is the primary plan and the plan that provides coverage due to part-time employment is the secondary plan.
- **Longer or shorter length of coverage.** The plan that covered the person as an employee, member, policyholder, subscriber, or retiree longer is the primary plan and the plan that covered the person the shorter period is the secondary plan.

If the preceding rules do not determine the order of benefits, the allowable expenses will be shared equally between the plans meeting the definition of other plan. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

See also the section entitled “Coordination of Plan Benefits with Medicare” at page 88.

Effect on the Benefits of this Plan

The Plan will pay benefits when this Plan is the primary plan. When this Plan is the secondary plan, it may pay the difference between benefits paid from the primary plan and the benefits payable by this Plan. ***However, the total benefits paid will not be more than what would have been paid if this Plan were primary.***

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply coordination of benefits rules and to determine benefits payable under this Plan and other plans. So long as it acts in compliance with HIPAA Privacy Rules, as described beginning on page 97, the City or the Claims Administrator may get the needed facts from or give needed facts to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Claims Administrator any facts it needs to apply those rules and determine benefits payable.

XVII. THIRD PARTY RECOVERY AND REIMBURSEMENT PROVISION

In the event the Plan provides benefits for Injury, Illness, Medical Care or other loss (the "Injury") to any person, the Plan is subrogated to all present and future rights of recovery that person, his parents, heirs, guardians, executors, or other representatives (individually and collectively called the "Participant") may have arising out of the Injury. The Plan's subrogation rights include, without limitation, all rights of recovery a Participant has: 1) against any person, insurance company or other entity that is in any way responsible for providing or does provide damages, compensation, indemnification or benefits for the Injury; 2) under any law or policy of insurance or accident benefit plan providing no fault, personal injury protection or financial responsibility insurance; 3) under uninsured or underinsured motorist insurance; 4) under motor vehicle medical reimbursement insurance; and, 5) under specific risk or group accident and health coverage or insurance, including, without limitation, premises or homeowners medical reimbursement, athletic team, school or workers' compensation coverage or insurance.

Upon notice of an Injury claim, the Plan may assert a subrogation lien to the extent it has provided, or may be required to provide, Injury-related benefits. Notice of either the Plan's right of subrogation or the Plan's subrogation lien is sufficient to establish the Plan's right of subrogation and entitlement to reimbursement from insurers, third parties, or other persons or entities against whom a Participant may have an Injury-related right of recovery. The Plan shall be entitled to intervene in or institute legal action when necessary to protect its subrogation or reimbursement rights.

The Participant and anyone acting on his behalf shall promptly provide the Plan or its authorized agents with information it deems appropriate to protect its right of subrogation and shall do nothing to prejudice that right and shall cooperate fully with the Plan in the enforcement of its subrogation rights. Reasonable attorney's fees and costs of Participant's attorney shall be paid first from any recovery by or on behalf of a Participant, and the amount of the Plan's subrogation claim shall be paid next from such recovery. Neither a Participant nor his attorney or other representative is authorized to accept subrogation or other Injury-related reimbursement payments on behalf of the Plan, to negotiate or compromise the Plan's subrogation claim, or to release any right of recovery prior to the payment of the Plan's subrogation claim.

The Participant and all other parties to a recovery are required to contact the Plan to determine, and arrange to pay the Plan's subrogation claim at or prior to the time an Injury-related payment or settlement is made to or for the benefit of the Participant. If the Participant obtains a payment or settlement from a party without the Plan's knowledge and agreement, the Plan shall be entitled to immediate reimbursement of its total subrogation claim from the Participant or any party providing any Injury-related payment. In the alternative, the Plan, in its sole discretion, may deny payment of benefits to or on behalf of the Participant for any otherwise covered claim incurred by the Participant until the amount of the unpaid coverage is equal to and offset by the unrecovered amount of the Plan's subrogation claim.

The Plan Administrator or its authorized agents are vested with full and final discretionary authority to construe subrogation and other Plan terms and to reduce or compromise the amount of the Plan's recoverable interest where, in the sole discretion of the Plan Administrator or its authorized agents, circumstances warrant such action. The Plan shall not be responsible for any litigation-related expenses or attorney fees with an Injury claim unless the Plan shall have specifically agreed in writing to pay such expenses or fees.

The payment of benefits to or on behalf of the Participant is contingent on both the Participant's full compliance with the Plan's provisions, including the subrogation provision, and when the Plan deems appropriate, the Participant's signing of a reimbursement agreement. However, the Participant's failure to sign this reimbursement agreement will not affect the Plan's subrogation rights or its right to assert a lien against any source of possible recovery and to collect the amount of its subrogation claim.

XVIII. HOW YOU CAN HELP CONTROL COSTS

If you discover an error on a bill and have the bill corrected, you will receive a portion of the amount saved by the Plan. Just bring and/or mail in a letter giving a brief explanation as to the overpayment, the original bill, corrected bill, and Explanation of Benefits (EOB) indicating the amount that the Claims Administrator paid towards the bill to the Benefits Management Division. You will receive 25% (up to a maximum of \$500) of the amount saved by the Plan. To be eligible under this program the amount recovered by the City must be at least \$10. However, please note that payments for an error resulting from the misplacement of a decimal are limited to \$250.

In addition to the above, you need to notify the Benefits Management Division if you believe another Participant has knowingly submitted claims for services that have not been received or for a Dependent who is not eligible for benefits. In this instance, you will receive 25% of any amounts actually recovered by the City, up to a maximum of \$500. To receive this, you must submit a properly executed written notice to the Benefits Management Division of allegedly inaccurate or improper claims submitted by another Participant. The notice must include the name of the Employee who may be submitting improper or inaccurate claims, the nature of the problem, and any other pertinent information.

Limitation of Payment

Payment will not be made if the:

- Employee does not notify the Benefits Management Division of the incorrect billing or fraud by a properly signed written notice;
- Situation is identified first by a member of the Benefits Management Division or other agency of the City assigned to investigate, audit, or adjudicate claims; or
- The City does not recover any amounts.

XIX. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) INFORMATION

A. HIPAA Privacy

This summary describes the circumstances under which the City, as Plan Sponsor, may use and disclose Protected Health Information (PHI) for payment, health care operations, and for other purposes that are permitted or required by law. It also describes a Participant's rights to access and control PHI. Capitalized terms that appear here and are not defined in the Definitions Section of this document have the meaning given to them in HIPAA.

PHI is information about a Participant, including demographic information, collected from a Participant or created and received by a health care Provider, a health plan, an employer, or a health care clearinghouse and that relates to the Participant's:

- Past, present, or future physical or mental illness or condition;
- Receipt of health care; or
- Past, present, or future payment of the provision of health care.

The City, through the Benefits Management Division, contracts with business associates to perform various functions or to provide certain types of services. To perform these services, business associates receive, create, maintain, use or disclose PHI. The City requires those business associates to agree in writing to contract terms that are designed to safeguard PHI.

The City contracts with Claims Administrators to process claims for Participants. The Benefits Management Division does not store claim records.

Permitted Uses and Disclosures

HIPAA allows a group health plan to use and disclose PHI for all activities that are included within the definitions of "payment" and "health care operations" as set out in 45 C.F.R. Section 164.501 (which is part of the HIPAA privacy regulations). The following list provides examples (not a complete list) of the uses and disclosures that the Plan Sponsor may make:

- **Payment.** Payment refers to the activities involved in the collection of premiums (monthly contributions) and the payment of claims under the plans for the services provided. Third parties, including pension funds and Claims Administrators, perform many of the payment activities for these Plans. Examples also include determining contribution rates and cost sharing responsibilities, obtaining payment under a reinsurance contract (stop-loss insurance), review of Medical Necessity, utilization review activities, claim review and appeal, sharing PHI with other insurers for coordination of benefits or subrogation, or sharing PHI with participating Provider networks or pharmacy benefits managers for billing and payment purposes.
- **Health Care Operations.** Health care operations refer to the basic business functions necessary to operate group health plans. Examples include

underwriting, customer service, or claim denial inquiries, quality assessments, cost impact studies, and fraud and abuse detection audits.

The Plan Sponsor may disclose PHI to another entity that has a relationship with the Participant and is subject to federal privacy rules, for its health care operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, or detecting or preventing health care abuse or fraud.

Other Permissible Uses

HIPAA also allows the Plan to use and disclose PHI, without consent or authorization, in the following ways:

- To the Participant;
- To a personal representative designated by a Participant to receive PHI, or a personal representative designated by law such as the parent or legal guardian of a child, or the surviving family members or representatives of the estate of a deceased individual;
- To the Secretary of Health and Human Services (HHS) or any employee of HHS as part of an investigation to determine the Plan Sponsor's compliance with HIPAA privacy rules;
- To a business associate as part of a contracted agreement to perform services for the group health plan provided that the Business Associate has agreed to safeguard the PHI;
- To a health oversight agency, such as the Department of Labor, the Internal Revenue Service, or the Insurance Commissioner's Office, to respond to inquiries or investigations of the Plans, requests to audit the Plans, or to obtain necessary licenses;
- In response to a court order or subpoena, discovery request, or other legal process meeting certain requirements;
- As required for law enforcement purposes;
- As required for compliance with workers' compensation laws; and
- For treatment alternatives.

The examples of permitted uses and disclosures listed above are not provided in an all-inclusive list. They are provided in general as examples only.

Disclosures to the Plan Sponsor

The Plan agrees that it will disclose PHI to the Plan Sponsor only if the Plan Sponsor agrees to abide by the following provisions:

- **Prohibition on Unauthorized Use or Disclosure of PHI.** The Plan Sponsor will not use or disclose any PHI received from the Plan, except as permitted in the Plan documents or as required by law.
- **Agents (including subcontractors).** The Plan Sponsor will require each of its agents, including subcontractors, to whom the Plan Sponsor provides PHI that it received from the Plan, to agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information.
- **Impermissible Purposes.** The Plan Sponsor will not use or disclose PHI for employment-related actions and decisions or in connection with any other of Plan Sponsor's benefits or Employee benefit plans.
- **Reporting.** The Plan Sponsor will report to the Plan any use or disclosure of PHI, of which it becomes aware, that is inconsistent with the uses and disclosures permitted by the Plan. Specifically, the Plan Sponsor will report to the Plan any Breach occurring on or after September 23, 2009, as defined by 45 CFR § 164.402.
- **Access to PHI by Participants.** The Plan Sponsor will make PHI available to the Plan to permit Participants upon request to inspect and copy their PHI to the extent provided by 45 CFR § 164.524.
- **Amendment of PHI.** The Plan Sponsor will make PHI available to Participants who request to amend or correct PHI that is inaccurate or incomplete and will incorporate any amendments to PHI to the extent required and/or permitted by 45 CFR § 164.526.
- **Breach Notification.** The Plan Sponsor will cooperate with the Plan's efforts to comply with the Breach notification regulations set forth in 45 CFR §§ 164.404, 164.406 and 164.408.
- **Accounting of PHI.** The Plan Sponsor will make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528.
- **Disclosure to the Secretary.** The Plan Sponsor will make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the Department of Health and Human Services or its designee to determine the Plan's compliance with HIPAA.
- **Return or Destruction of PHI.** When the PHI is no longer needed for the purpose for which disclosure was made, the Plan Sponsor must, if feasible, return to the Plan or destroy all PHI that the Plan Sponsor received from the Plan, and retain no copies in any form. If return or destruction is not feasible, the Plan Sponsor agrees to limit further uses and disclosures to the purposes that make the return or destruction infeasible.

- **Adequate Separation.** The Plan Sponsor must ensure that adequate separation exists between the Plan and Plan Sponsor so that PHI will be used only for Plan administration. The following Employees, classes of Employees, or persons under the control of the Plan Sponsor may have access to and may use PHI, but only to the extent necessary to perform the administration functions that are to be performed by the Plan Sponsor as set forth above, and are assigned to such Employees as a part of their job duties:
 - An officer, Employee, or committee thereof that serves as Plan Administrator;
 - An officer or Employee who serves as a Plan fiduciary;
 - An officer or Employee who serves as the Privacy Officer under HIPAA;
 - An Employee that performs human resources or personnel functions;
 - An Employee that performs accounting, finance, or payroll functions with respect to the Plan;
 - An Employee that provides legal services to the Plan;
 - An Employee who provides information technology services with respect to the Plan; and
 - Any Employee performing similar functions to those listed above.

In the event that any such persons do not comply with the City's HIPAA requirements, such persons will be subject to disciplinary action by the Plan Sponsor for noncompliance, pursuant to the Plan Sponsor's discipline and termination or removal procedures. The Plan Sponsor will take whatever actions necessary to resolve such noncompliance. Regardless of whether a person is disciplined, terminated, or removed, the Plan reserves the right to direct that Plan Sponsor modify or revoke any person's access to or use of PHI, and the Plan Sponsor will take such action as warranted. Anyone who suspects improper use or disclosure of PHI may report the occurrence to the Plan's Privacy Officer at the telephone number and address provided in the Plan's notice of privacy practices.

In adopting the above HIPAA privacy provisions, the City hereby certifies that it will abide by such provisions.

B. HIPAA Security

Plan Sponsor's Use and Disclosure of Electronic PHI.

- The Plan Sponsor has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan, and that support the adequate separation that is required by 45 CFR § 164.504(f)(2)(iii).

- The Plan Sponsor will ensure that any agent (including a subcontractor) to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the information.
- The Plan Sponsor will report to the Plan any security incident of which it becomes aware. For purposes of this provision, a security incident is an attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

XX. PLAN FINANCING/COST OF COVERAGE

Funding

The Plan is self-funded. The Plan has an Administrative Services Only (ASO) agreement with its Claims Administrator, meaning the Claims Administrator only processes claims. Likewise, the City, on behalf of the Plan, has a services agreement with the Prescription Benefit Manager. Through its contracts with the Claims Administrator and/or Prescription Benefit Manager, the City may receive discounts, rebates or other allowances from Providers and/or the Prescription Benefit Manager.

This Plan provides benefits in conjunction with the City's Pre-Tax Contribution Plan and is hereby incorporated as applicable into the City's Pre-Tax Contribution Plan by reference. The City and Employees contribute to the cost of this Plan. The Employee's cost is paid on a Before-Tax Basis as described in the City of Chicago Pre-Tax Contribution Plan.

The City pays a substantial portion of the cost of your medical benefits. Your share of the cost may change each year.

If you enroll, except in the case of certain Domestic Partner benefits, your cost for coverage will be deducted on a Before-Tax Basis. As a result, your taxable income will be reduced by the amount of your premiums. You won't pay any federal or state taxes (or Social Security or Medicare taxes, if applicable) on your premiums. Since your taxable income will be lower, your taxes will be lower as well. However, under federal law, the contribution deduction for Domestic Partners is taken on an after-tax basis and is therefore subject to applicable payroll taxes unless you can demonstrate that your Domestic Partner or Civil Union Spouse is a tax-qualified dependent for this purpose under the Internal Revenue Code.

Health Care Contribution Rates

Health care contributions are based on salary and level of coverage as of January 1 each year. If the level of coverage or your salary is changed during the Plan Year, pursuant to the City's Pre-Tax Contribution Plan, the contribution amount will increase or decrease accordingly.

Your cost for medical coverage is based on your salary and level of coverage. If you change your level of coverage during the year because of a Family Status Change, your cost will increase or decrease accordingly. In addition, your cost will be adjusted during the year to reflect changes in your salary.

Your cost will be automatically deducted from your paycheck before taxes are figured. Consult with your tax advisor if you have any questions about before-tax premiums. Costs for those not Actively at Work and not receiving paid or extended sick leave benefits and otherwise eligible to continue coverage, as well as instructions on how to make payment, are available from the Benefits Service Center.

Chicago Lives Healthy Wellness Program

Covered Employees and their covered Spouse, Domestic Partner, or Civil Union Spouse are given the opportunity during the Plan's annual open enrollment period each year to

participate in the Chicago Lives Healthy Wellness Program. Under this program, participants are required to complete a “well-being assessment” and receive a free biometric screening prior to a certain date. Then, each Participant must by a certain date discuss by phone with the Wellness Program Administrator (identified in the “Important Contact Information” section earlier in this document) the results, and the Wellness Program Administrator will create a “well-being plan,” and make recommendations regarding ongoing wellness program participation, including possible additional free health check-ins and health risk coaching.

Covered Employees and their covered Spouse, Domestic Partner, or Civil Union Spouse who choose not to participate in the Chicago Lives Healthy Wellness Program will incur an additional \$50 per non-participant increase in their monthly employee contribution.

Please note that in order to avoid the \$50 extra charge, you are not required to prove that you have succeeded in achieving a certain health goal (such as lowering your blood pressure, losing weight, or quitting smoking). And you will not be required to pay more simply because you suffer from any particular Illness. All that is required is that you participate in each step of the Chicago Lives Healthy Wellness Program.

All Employees Except Crossing Guards

The following information applies to all Employees, except crossing guards hired before January 1, 2006. Rates are on a per pay period basis for Employees paid on a semi-monthly basis. If you are not paid on semi-monthly basis, rates will be adjusted to reflect the annual level of contribution required under the Plan. Premiums will be automatically deducted from your paycheck before taxes are calculated. Premiums may change each year. The current rates are available from the Benefits Service Center. You will be notified about rate changes as they occur.

The following formulas are applied to your annual salary coupled with your level of coverage to determine your contribution per pay period. The following illustrates how rates per pay period are established for Employees who are Actively at Work.

Healthcare Contribution Rates per Pay Period*

Annual Salary	Single	Level of Coverage Employee + 1	Family
Up to \$30,000 (flat rate)	\$15.71	\$23.88	\$27.65
\$30,001 to \$89,999	1.2921% of gross divided by 24	1.9854% of gross divided by 24	2.4765% of gross divided by 24
\$90,000 and over (flat rate)	\$48.45	\$74.45	\$92.87

**** Covered Employees and their covered Spouse, Domestic Partner, or Civil Union Spouse who choose not to fully participate in the Chicago Lives Healthy Wellness Program will incur an additional \$50 per non-participant increase in their monthly employee contribution. In other words, if an employee and covered Spouse/Domestic Partner/Civil Union Spouse each choose not to participate or do not complete the required steps to enroll***

and participate in the Chicago Lives Healthy Wellness Program, the increase in the monthly employee contribution will be \$100 (\$50 per non-participant).

The following examples are provided to clarify the payroll deductions (2006 rates are used for illustrative purposes; each example assumes that the person in fact participates in the Wellness Program):

<p>Example 1: If your annual salary is under \$30,000, and you enroll for single coverage, your contribution will be a flat \$15.71.</p> <p>As your salary increases over \$30,000, your contribution per pay period will increase accordingly.</p>	<p>Example 2: If your annual salary is \$46,000, your contribution will be calculated as follows:</p> <p>Single: \$46,000 x .012921 divided by 24 = \$24.76</p> <p>Employee + 1: \$46,000 x .019854 divided by 24 = \$38.05</p> <p>Family: \$46,000 x .024765 divided by 24 = \$47.46</p> <p>This calculations can be computed for any salary from \$30,001 to \$89,999 depending on the level of coverage. As your salary increases, your contribution per pay period will increase accordingly.</p>
<p>Example 3: If your annual salary is \$90,000 or more, your contribution is capped at a flat rate:</p> <p>Single: \$48.45 Employee + 1: \$74.45 Family: \$92.87</p>	

Veteran Crossing Guards

Crossing Guards hired before January 1, 2006 are eligible for health benefits during the unpaid summer break (if they were enrolled prior to the start of the break). Therefore, rates have been calculated to deduct before-tax premiums for the benefit year into 18-day periods. This allows premiums for the entire year to be deducted in nine months.

The following illustrates how rates are established for veteran crossing guards Actively at Work and hired before January 1, 2006.

Healthcare Contribution Rates for Veteran Crossing Guards (hired prior to January 1, 2006)*

Annual Salary	Level of Coverage		
	Single	Employee + 1	Family
Up to \$30,000 (flat rate)	\$20.95	\$31.84	\$36.87
\$30,001 to \$89,999	1.2921% of gross divided by 18	1.9854% of gross divided by 18	2.4765% of gross divided by 18

**** Covered Employees and their covered Spouse, Domestic Partner, or Civil Union Spouse who choose not to participate in the Chicago Lives Healthy Wellness Program will incur an additional \$50 per non-participant increase in their monthly employee contribution. In other***

words, if an employee and covered Spouse/Domestic Partner/Civil Union Spouse each choose not to participate, the increase in the monthly employee contribution will be \$100 (\$50 per non-participant).

Claim Administrator's Separate Financial Arrangements With Providers

The PPO Plan Claims Administrator has contracts with certain Providers ("Plan Providers"), including PPO Providers, in Illinois and other states to provide and pay for health care services to all persons entitled to health care benefits under individual certificates and group contracts to which the Claims Administrator is a party, including all persons covered under this Plan. Pursuant to its contracts with Plan Providers, under certain circumstances described therein, the Claims Administrator may receive substantial payments from Plan Providers with respect to services rendered to all such persons for which the Claims Administrator was obligated to pay the Plan Provider, or the Claims Administrator may pay Plan Providers less than their charges for services, by discount or otherwise, or may receive from Plan Providers other allowances under the Claims Administrator's contracts with them. In negotiating the terms of its service agreement with the Claims Administrator, the Plan Sponsor has taken into consideration that the Claims Administrator may receive such payments, discounts and/or other allowances during the term of such agreement. These discounts or allowances may be retained by the Plan Sponsor to help offset its costs for the medical plans, including administrative fees or charges. Further, all required Deductible, Co-insurance, and Copayment amounts under this Plan shall be calculated on the basis of the Provider's charges for services rendered to a Participant.

In the case of Physicians and certain other professional providers, the calculation of all benefits shall be based on the Schedule of Maximum Allowances for these Providers.

To help you understand how the Claim Administrator's separate financial arrangements with Providers work, please consider the following example:

- a. Assume you go into a PPO Hospital for one night and the normal, full amount the Hospital bills for Covered Expenses is \$1,000. How is the \$1,000 bill paid?
- b. You personally will have to pay the Deductible and Coinsurance amounts set forth in this Plan's Schedule of Benefits. Both the Deductible and Coinsurance amounts are based on the Hospital's charges, which are usually the full amount the Hospital normally bills for services you receive, or in this example, \$1,000.
- c. Assuming you have already satisfied your Deductible, you will still have to pay the Coinsurance portion of the \$1,000 Hospital bill. For example, if your Coinsurance obligation is 10%, you personally will have to pay 10% of \$1,000, or \$100.
- d. After taking into account the Deductible and Coinsurance amounts, the Claims Administrator will satisfy its portion of the Hospital bill. In most cases, the Claims Administrator has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money the Claims Administrator would be required to pay if it did not have a contract with the Hospital.

So, in the example we are using, since the full Hospital bill is \$1,000, your deductible has already been satisfied, and your Coinsurance is \$100, then the Claim Administrator is obligated

to satisfy the rest of the Hospital bill. However, assuming the Claims Administrator has a contract with the Hospital, the Claims Administrator will usually be able to satisfy the bill that remains after your Coinsurance and Deductible by paying less than \$900 to the Hospital.

XXI. PLAN ADMINISTRATOR AND ADMINISTRATION/PLAN AMENDMENT AND TERMINATION

The City is the Plan Administrator. The City may appoint one or more persons or the Benefits Management Division or the Benefits Service Center to act as its agent or delegate to aid in carrying out administrative duties.

Plan Administrator's Rights, Powers, and Duties

The Plan Administrator reserves the authority and absolute fiduciary discretion as may be necessary to discharge Plan responsibilities. The Plan Administrator has the rights, powers, and duties to:

- From time to time, adopt rules governing procedures not inconsistent with this document and keep a permanent record of actions;
- Administer the Plan uniformly and consistently with respect to persons who are similarly situated;
- Waive enforcement of Plan terms on a non-discriminatory basis and settle claims and disputes;
- From time to time, prepare and file reports as may be required by law;
- Administer the benefits provided under the Plan in a manner that is not discriminatory in favor of highly compensated City Employees as defined under the Internal Revenue Code;
- Set employee contribution rates;
- Be the sole fiduciary responsible, through its Benefits Committee, for the administration of the Plan;
- Delegate its administrative duties and contract with service providers as it sees fit; and
- Interpret, as an exclusive right and power in its fiduciary discretion, the provisions of the Plan and to determine any ambiguities arising under the Plan or in connection with the administration of the Plan, including the remedying of any omission, inconsistency, or other ambiguity; its decision or action in respect thereof is conclusive and binding upon any and all Participants or former Participants.

The Plan Administrator may employ counsel and agents in clerical, medical, accounting, legal, and other services as it may require in carrying out Plan provisions.

The Plan Administrator will discharge its duties, in its sole and absolute fiduciary discretion:

- For the exclusive purposes of providing benefits to Employees or former Employees and, at the fiduciary discretion of the City, defraying reasonable expenses of Plan administration; and
- With the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

Amendment and Termination

The City may amend or terminate the Plan for any class of Employees and/or Dependents at any time and for any reason, and may, at its sole discretion, delegate the power to amend or terminate this Plan to the Benefits Management Division as long as any amendment or termination does not violate the terms of any collective bargaining agreement.

Amendment or termination must be in writing; oral modifications are not permitted.

XXII. DEFINITIONS

Throughout this PPO booklet, many words are used that have a specific meaning when applied to your health care coverage. When you come across these terms (usually capitalized) while reading this PPO booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. All definitions have been arranged in alphabetical order. While most terms are defined here, some definitions instead may be found elsewhere in the text of this PPO booklet.

Accidental Injury

A severe Injury that requires immediate attention by a licensed Doctor/Physician.

Actively at Work

As an Employee, you are considered to be Actively at Work if you perform a full normal workday consisting of your regular duties of employment at the City's regular place of business or another location to which you may be required to travel to perform your regular duties with the City.

Affordable Care Act

The Patient Protection and Affordable Care Act of 2010 (also known as the Health Care Reform Act).

Allowable Charge

A. For Providers Other than Professional Providers

For PPO Providers who are not Professional Providers, the amount determined by the Claims Administrator that the PPO Provider has agreed to accept as payment in full for a particular covered service. For Non-PPO Providers who are not Professional Providers, the Allowable Charge will be the lesser of the Provider's billed charges or an amount determined by the Claims Administrator which currently is developed from the rate of base Medicare reimbursements and represents approximately 100% of the base Medicare rate and excludes any Medicare adjustment(s) based on claim information. For out of network coordinated home care services, the Allowable Charge will be 50% of the billed charge.

In processing non-PPO Claims, the Claim Administrator will use the same Claim processing rules and/or "edits" that it uses to process PPO Claims. The application of these rules or edits may allow the Allowable Charge for any particular service. In the event the Claims Administrator does not have any rules or edits for a particular service, the Claims Administrator may use the claim rules or edits that are used by Medicare when it processes claims; however, the use of Medicare claim rules or edits will not require any additional payments that are Medicare-specific (such as but not limited to "disproportionate share payments" and "graduate medical education payments" as defined under Medicare).

B. For Professional Providers

The amount determined by the Claims Administrator that PPO Providers have agreed to accept as payment in full for a particular covered service. All benefit payments under the Plan for covered Services rendered by Professional Providers, whether PPO or Non-PPO, will be based on the Allowable Charge. These amounts may be amended from time to time by the Claims Administrator pursuant to its contracts with the PPO Providers. For claims submitted for services received from non-PPO Professional Providers, the Claim Administrator will use the same Claim processing rules and/or “edits” that it uses to process PPO professional claims. The application of these rules or edits may allow the Allowable Charge for any particular service. In the event the Claims Administrator does not have any rules or edits for a particular service, the Claims Administrator may use the claim rules or edits that are used by Medicare when it processes claims. (Just as one of many examples, Medicare applies a “multiple procedures” rule whereby it pays less than it would otherwise for a second procedure that uses the same surgical opening, on the theory that the surgery takes less time than two separate surgeries would and therefore should not cost as much.) However, the use of Medicare claim rules or edits will not require any additional payments that are Medicare specific (such as but not limited to “disproportionate share” payments” and “graduate medical education payments” as defined under Medicare).

Ambulance Transportation

Medically Necessary local transportation to receive Emergency Medical Care in a specially equipped ambulance from home, the scene of an accident or a medical emergency to a Hospital or between one Hospital and another Hospital. If there are no facilities in the local area equipped to provide the care needed, ambulance transportation then means the transportation to the closest facility that can provide the necessary service.

Ambulatory Surgical Facility

A facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and that is duly licensed by the appropriate state and local authority to provide such service.

Anesthesia Services

The administration of anesthesia and the performance of related procedures by a Physician or a certified registered nurse anesthetist that may be legally rendered by them respectively.

Behavioral Health Specialist

One of the following Professional Providers:

- Psychiatrist.
- Licensed clinical professional counselor (LCPC).
- Clinical psychologist.

- Psychiatric or medical social worker.
- Licensed chemical dependency counselor.
- Neuropsychologist.
- Licensed marriage and family therapist.
- Board certified behavioral analyst or assistant behavioral analyst.
- Physician assistant.
- Licensed professional counselor.
- Licensed social worker.

Benefits Committee

The Benefits Committee oversees the operation of the Plan and interprets Plan provisions in its sole fiduciary discretion and consists of the Budget Director, City Comptroller, Commissioner of Human Resources, Benefits Manager, and the Chairman of the Committee on Finance, or their respective designees.

Benefits Management Division

A division of the City's Finance Department with primary responsibility for the management of benefits offered to Employees of the City. This Division is run by the Benefits Manager.

Benefits Service Center

A third party administrator authorized by the City to administer eligibility and enrollment with respect to the Plan.

Blue Distinction Centers

Blue Distinction is a designation given by the Claims Administrator to healthcare facilities (typically hospitals) that have demonstrated expertise and proficiency in delivering certain healthcare services.

Calendar Year/Plan Year

A period of one year, beginning on January 1 of each year and running until December 31.

Carryover Deductible

Charges applied to the Deductible for services incurred during the last three months of a Calendar Year that may be used to satisfy the following year's Deductible.

Certified by the Medical Advisor

With respect to certain treatments or services, this means that the Participant has contacted the Medical Advisor in compliance with the Medical Advisor Review Program, and, as required by that program, has obtained certification from the Medical Advisor that the treatment and services are Medically Necessary. In some instances, the Covered Person must contact the Medical Advisor in advance of receiving care. Refer to the Medical Advisor Review Program section. Plan benefits may be reduced or may not be available if the requirements of the Program are not followed. When the Medical Advisor properly has been contacted and has approval (if required) the treatment or services, the treatment or services are considered to have been “Certified by the Medical Advisor.”

City

The City of Chicago.

Civil Union Spouse

A party who has entered into a “civil union,” as defined by the Illinois Religious Freedom Protection and Civil Union Act, with the Employee.

Claim

Notification in a form acceptable to the Claims Administrator that a service has been rendered or furnished to you and request for payment of benefits under this Plan. This notice must include full details of the service received.

Claims Administrator

An organization employed by the Plan to administer the PPO network, verify eligibility, determine Medical Necessity in certain circumstances, and administer Plan provisions. The Claims Administrator is identified in the Important Contact Information section.

Coinsurance or Co-Insurance

A percentage of an eligible expense that a Participant is required to pay toward a Covered Service as set forth in the PPO Plan Schedule of Benefits in Article IV.

Copayment or Co-Payment

A flat dollar amount that a Participant is required to pay towards the cost of certain services or supplies.

Covered Expenses

Charges for eligible medical services and supplies, described beginning on page 43, provided the services and supplies are determined to be Medically Necessary for the treatment of Injury or Illness (as defined below), and provided the charges do not exceed Usual and Customary Charges.

Custodial Care

Services or treatment, regardless of where provided, that:

- Could be rendered safely by a person without medical skills; and
- Are designed mainly to help the patient with daily living activities, including, but not limited to:
 - Personal care, such as help in walking, getting in and out of bed, bathing, eating by spoon, tube, or gastrostomy (G tube), exercising, dressing, administering an enema, and using the toilet;
 - Homemaking, including, but not limited to, services such as preparing meals or special diets;
 - Moving the patient;
 - Acting as a companion or sitter;
 - Supervising medication that can usually be self-administered;
 - Diabetes monitoring that can usually be self-administered;
 - Oral hygiene; and
 - Ordinary skin and nail care.

The Claims Administrator's medical staff and/or the Medical Advisor determine what services are considered custodial care under the Plan.

Deductible, Individual Deductible, or Individual Deductible Amount

The amount of Covered Expenses a Participant must pay first each Calendar Year before benefits are paid by the Plan, as set forth in the PPO Plan Schedule of Benefits in Section IV. The individual deductible amount applies separately to each Participant, except as provided under the Family Deductible. If a Participant does not satisfy the individual deductible amount by the end of the Calendar Year, any Covered Expenses applied to the deductible and incurred during October, November, or December of that Calendar Year will be applied to the Individual Deductible Amount for the following Calendar Year.

Dependent

The Employee's Spouse, Domestic Partner, Civil Union Spouse, or child, provided such individuals otherwise meets the requirements to be eligible for coverage under the Plan as set forth on page 14 in the section entitled "Eligibility, Enrollment, and Termination of Coverage."

Doctor

See "Physician" below; the two terms are used interchangeably

Domestic Partner

A qualified, same sex domestic partner within the meaning of, and who has satisfied the requirements of, City of Chicago Municipal Code Section 2-252-072.

Durable Medical Equipment (DME)

Equipment that is:

- Durable, non-consumable, and not considered by the Plan to be a normal household item;
- Made for and mainly used in the treatment of an Illness or Injury covered by the Plan;
- Made to withstand prolonged use;
- Suited for use while not confined as an inpatient in the Hospital;
- Not normally of use to persons who do not have an Illness or Injury;
- Related to your condition and prescribed by your Physician acting within the scope of his or her license to use in your home;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Duty Disability

Duty Disability is defined by the applicable pension fund.

Emergency Accident Care

The initial outpatient treatment of an Accidental Injury, including related diagnostic service, within 72 hours of an accident.

Emergency Medical Care

The initial outpatient treatment, including related diagnostic services, received within 24 hours of the onset of a severe medical condition that (i) results in symptoms that occur suddenly and unexpectedly; and (ii) requires immediate Physician's care to prevent death or serious impairment of a Participant's health, or poses a serious threat to the Participant or to others.

Examples of such symptoms are severe chest pains, convulsions, or persistent and severe abdominal pains.

Emergency Room Copayment

The Copayment for each Hospital emergency room visit. This Copayment is waived if you are admitted as an in-patient to the Hospital.

Employee

An employee on the regular payroll of the City.

Experimental or Investigational

Treatment considered experimental in terms of generally accepted medical practice. This includes:

- Procedures, drugs, devices, services, and/or supplies that:
 - Are provided or performed in special settings for research purposes or under a controlled environment and that are being studied for safety, efficiency, and effectiveness; and/or
 - Are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to you; and
- Drugs, combination of drugs and/or devices, that are not approved by the Food and Drug Administration for the purpose for which they are administered to you at the time they are used or administered to you.

Family Deductible or Family Deductible Limit

The maximum amount of Covered Expenses a family (including the covered Employee and his or her covered Dependents) must pay first each Calendar Year before Plan benefits are paid for all family members, as described in the How the Medical Care Plan Works section on page 42. When the Family Deductible is reached in a Calendar Year, each Family Member is considered to have met the Individual Deductible for the rest of the Calendar Year.

Family Status Change

Family Status Changes allow you to add or discontinue coverage for eligible Dependents at a time other than the annual open enrollment period. Family Status Changes include:

- A change in marital status (marriage or divorce);
- Formation of or dissolution of a civil union or domestic partnership;
- The birth, adoption, or placement for adoption of a child;
- The death of an eligible Dependent;

- A loss of health insurance maintained by you and/or an eligible Spouse due to a loss of eligibility for such other coverage (including the exhaustion of COBRA coverage); and
- A Dependent child reaching the Plan's age limit.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 and the regulations thereunder.

Home Health Care Program

An organized skilled patient care program in which care is provided in the home. Such home care may be rendered by a Hospital's duly licensed home health department or by other duly licensed home health agencies. The Participant must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and must require Skilled Nursing Care on an intermittent basis under the direction of a Physician. This program includes, among other things, Skilled Nursing Care by or under the direction of, a Nurse, and the services of occupational/physical therapists, Hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for private duty nursing services.

Hospice

An organization that provides a centrally administered program of palliative (relief from pain) and support services to the terminally ill and their families. Services are provided by a medically supervised team of professionals and volunteers.

Hospital

An institution that:

- Is licensed as a hospital in the jurisdiction where it is located;
- Provides 24-hour-a-day Skilled Nursing Care by Nurses;
- Keeps a medical record of each patient;
- Keeps an ongoing quality assurance program with review by Physicians;
- Charges for its services and supplies; and
- Although it provides medical or psychiatric treatment, is not mainly a:
 - Nursing home or convalescent or extended care facility;
 - Place for rest or the aged;
 - Place for drug addicts or alcoholics;

- Place that provides educational or behavioral modification services in a residential setting for children or adolescents with behavioral or social problems, mental retardation, or autism;
- Place of career advice, job training, or vocational rehabilitation; or
- Place to reside, play, or exercise.

Hospital Care

Services and supplies provided by a Hospital, including:

- Hospital room, board, and general nursing care; and
- Hospital intensive care while confined in an intensive care accommodation.

Illness

Illness means only a disease or sickness, including pregnancy, infertility, and substance addiction, which requires treatment by a Physician.

Infertility

The inability to conceive after twelve (12) consecutive months of unprotected intercourse despite purposeful attempts at pregnancy or the inability to conceive after twelve (12) consecutive months of at least three (3) Physician-supervised intrauterine insemination treatments, or the inability to sustain a successful pregnancy. The inability to sustain a successful pregnancy is defined as the third miscarriage that occurs before 12 weeks of gestation or the first spontaneous pregnancy loss that occurs after 12 weeks of gestational age.

Injury

Injury means only injury that requires treatment by a Physician.

Inpatient

The term Inpatient refers to services, supplies, and treatment received while admitted to a Hospital.

Maintenance Medications

Prescription drugs used on an ongoing basis for treatment of chronic conditions, such as diabetes, ulcers, or high blood pressure.

Maintenance Therapy

Occupational therapy, physical therapy, or speech therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

Medical Advisor

The third party service provider responsible for administering the Medical Advisor Review Program.

Medical Advisor Review Program

A health care function offered by the City to certify hospital confinements and other treatment and services for you and your Dependents, explain alternatives to Hospital Care and facilitate the early discharge of a hospital patient. More information starts on page 35.

Medical Care

Medical care and treatment by a Physician, including the professional services of a radiologist, pathologist, or other specialist acting within the scope of his or her license. The care or treatment must be for a service covered under the Plan and must be for treatment of an Illness or Injury.

Medically Necessary or Medical Necessity

“Medical Necessity” exists when services and supplies are “Medically Necessary” as defined herein. Medically Necessary services and supplies include:

- A service, supply, or course of treatment that is customary for the treatment or diagnosis of an Illness or Injury, and is consistent with generally accepted medical standards. The service, supply, or course of treatment must not involve the use of drugs that are not approved by federal authorities. The eligible expense must be determined to be Medically Necessary.
- The Claims Administrator will initially determine if a service or supply is Medically Necessary. The Plan will not pay for the cost of hospitalization or any other health care services or supplies that are not Medically Necessary. The judgment of the Claims Administrator relates only to benefits coverage under this Plan. The Participant should not use the availability of benefits coverage to determine what Medical Care or treatment the Participant receives or Participant's Dependents decide to receive.
- Hospitalization, for purposes of benefit coverage only, will be considered to be Medically Necessary when the medical services received require a Hospital inpatient setting. If services could appropriately be provided in the Doctor's office, the outpatient department of a Hospital or some other setting without adversely affecting the Participant's condition, hospitalization will be considered not Medically Necessary.

Here are some examples of hospitalization and other services that are not Medically Necessary:

- Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, such as a Doctor's office or Hospital outpatient department;
- Hospital admissions primarily for diagnostic studies (X-ray, laboratory, and pathology services and diagnostic tests) that could have been provided safely and adequately in some other setting, such as a Doctor's office or Hospital outpatient department;
- Continued inpatient Hospital Care when the patient's medical symptoms and condition no longer required a continued Hospital stay;
- Hospitalization or admission to a Skilled Nursing Facility, nursing home, or other facility for the primary purpose of providing Custodial Care, convalescent care, rest cures, or domiciliary care to the patient or for the convenience of the patient or Doctor;
- Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or Doctor or because care in the home is not available or is unsuitable; and
- The use of skilled or private Nurses to assist in daily living activities of routine supportive care, or to provide services for the convenience of the patient and/or his or her family.

Refer to the Medical Plan Exclusions section on page 59 of this PPO booklet.

Note: A determination by the Plan regarding Medical Necessity is merely a decision regarding provision of coverage under the Plan. **Decisions as to the appropriate treatment and care must be made by you in consultation with your Physician.**

Medicare

The program established by Title XVIII of the Social Security Act (Federal Health Insurance for the Aged) and the regulations thereunder.

Modality

Any physical agent applied to produce therapeutic changes to biologic tissue, including, but not limited to thermal, acoustic, light, mechanical, or electrical energy.

Non-PPO Provider

A health care Provider that is not a PPO Provider. Because such Providers do not have agreements obligating them to accept a negotiated rate for services (the "PPO Allowance Charge"), they may "balance bill" the Participant for the difference between what the Plan pays them and their full charges.

Non-Participating Pharmacy

A pharmacy that is not part of the Pharmacy Benefit Management Program.

Nurse

A registered nurse (RN) or a licensed practical nurse (LPN) who is either licensed under the law of the state in which such nurse practices or is registered by an organization operated with the approval of the American Medical Association.

Occupational Disability

This term is defined by the applicable pension fund (police or fire).

Ordinary Disability

A leave of absence approved by the applicable pension fund as “ordinary,” not duty related.

Out-of-Pocket Limit

The limit a Participant is required to pay under this Plan, which is set forth in the PPO Plan Schedule of Benefits in Section IV and includes:

- The Deductible Amount;
- Coinsurance amounts.

Once the Out-of-Pocket Limit is met, the Plan pays 100% of most Covered Expenses for the remainder of the Calendar Year.

Outpatient

The term “Outpatient” is used to describe services, supplies and treatment received while at a Hospital but not admitted, or received outside of a Hospital.

Participant

An individual who meets the Plan's eligibility requirements as an Employee and/or Dependent, as described in the Eligibility Enrollment and Termination of Coverage section on page 13.

Participating Pharmacy

A pharmacy that is part of the City's Prescription Drug Program network and accepts the PPO's prescription drug program card.

Pharmacy Benefit Manager or Prescription Benefit Manager (PBM)

An entity, separate from the City, or the Claim Administrator, that manages the Prescription Drug Program and that establishes the arrangements and discounts for prescription benefits.

Pharmacy Network

The pharmaceutical Providers, including both retail and mail order Providers, who have arrangements with the Pharmacy Benefits Manager, the Plan Administrator, or the Claim Administrator to provide Prescription Drugs to Covered Persons.

PHSA COBRA Administrator

The PHSA COBRA Administrator is an organization employed by the Plan to administer coverage under PHSA COBRA as described in Section II.J, and is identified in the Important Contact Information section.

Physician

A legally qualified practitioner of the healing arts acting within the scope of his/her license and as defined under the laws of the state where the treatment is rendered (used interchangeably with the term “Doctor”).

Plan

The amended and restated City of Chicago Medical Care Plan For Employees as set forth in this document.

Plan Sponsor or Plan Administrator

The City of Chicago.

Plan Year

The Plan Year is the Calendar Year.

PPO Provider

A Provider that has a written agreement with the Claims Administrator or an affiliate of the Claims Administrator in another state to provide services to you at the time services are rendered to you.

Such Providers have agreed not to bill Plan Participants amounts in excess of a negotiated amount (the “Allowable Charge”). Therefore, the Participant is responsible only for the Deductible, Coinsurance or Copayment amounts, and non-covered services.

Pre-Certification/ Pre-Admission Certification/Prior Authorization

The certification process by the Medical Advisor Review Program, the Claims Administrator, or Pharmacy Benefit Manager, as applicable, before receipt of certain services or supplies as specified in this document or admission to a Hospital.

Prescription Drug Program

The program where eligible Employees or their Dependents obtain Prescription Drugs from a Participating Pharmacy.

Prescription Drugs

Drugs or medicines that require a Doctor's signature to dispense and are approved by the U.S.F.D.A. for use in treating the Illness or Injury for which they are prescribed.

Primary Care

Services rendered by or in the office of a gynecologist, obstetrician, pediatrician, internist, or Doctor of family medicine or general practice or by a certified nurse midwife, certified nurse specialist, certified nurse practitioner, Behavioral Health Specialist, retail health clinic or an immediate care center.

Professional Provider

Professional Providers are non-facility Providers, and include the following:

- Physicians.
- Podiatrists.
- Psychologists.
- Certified nurse-midwives.
- Chiropractors.
- Clinical social workers.
- Laboratories.
- Certified registered nurse anesthetists.
- Physical therapists.
- Occupational therapists.
- Speech therapists.

Provider

Any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician) or entity duly licensed to render Covered Services to Covered Persons.

Providers include Hospitals, Skilled Nursing Facilities, Ambulatory Surgical Facilities, Licensed Outpatient Clinics, and the individual professionals identified under the definition of Professional Provider.

Psychologist

A Registered Clinical Psychologist.

- **Registered Clinical Psychologist**: A Clinical Psychologist who is registered with the Illinois Department of Professional Regulation pursuant to the Illinois Psychologists Registration Act or, in a state where statutory licensure exists, the Clinical Psychologist must hold a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, such person must meet the qualifications specified in the definition of a Clinical Psychologist.
- **Clinical Psychologist**: A psychologist who specializes in the evaluation and treatment of mental illness and who meets the following qualifications:
 - Has a doctoral degree from a regionally accredited university, college or professional school; and has two years of supervised experience in health service of which at least one year is post-doctoral and one year is in an organized health services program; or
 - Is a Registered Clinical Psychologist with a graduate degree from a regionally accredited university or college; and has not less than six years as a psychologist with at least two years of supervised experience in health services.

Public Health Service Act (PHSA) COBRA

The federal law (42 USC §§201 et seq.) requiring the provision of health care continuation coverage to employees of state and local governments. The PHSA is for public service employees and is the equivalent of COBRA, which is for private sector employees.

Residential Treatment Center

A facility that specializes in 24 hour-a-day mental health and substance abuse care and treatment. The Residential Treatment Center must:

- Be licensed for the type of treatment provided;
- Be licensed by the state in which it is located; and
- Not be primarily for patient education.

Skilled Nursing Care

Those services provided by a Nurse that require the technical skills and professional training of a Nurse that cannot reasonably be taught to a person who does not have specialized skill and professional training. Skilled nursing services do not include Custodial Care service.

Skilled Nursing Facility

An institution or a distinct part of an institution that is primarily engaged in providing comprehensive skilled nursing services and rehabilitative inpatient care that is duly licensed by the appropriate governmental authority to provide such service. The skilled nursing facility must:

- Maintain all facilities necessary for medical treatment;
- Provide treatment under the supervision of Physicians;
- Provide nursing service 24 hours every day on an in-patient basis;
- Maintain daily clinical records on all patients; and
- Have available at all times the services of a Physician for necessary medical treatment.

A skilled nursing facility does not include any institution or part of an institution that is used primarily for education care or Custodial Care.

Specialist

Any Physician other than an internist, gynecologist, obstetrician, Behavioral Health Specialist, pediatrician, or Doctor of family medicine or general practice. For example, a chiropractor, cardiologist, endocrinologist, gastroenterologist, rheumatologist, neurologist, and oral surgeon all are considered Specialists.

Specialty Pharmacy

A program for provision of certain drugs, including some drugs that are injectable or administered through infusion, high cost, or have special delivery or storage requirements (such as refrigeration), as described under “Specialty Pharmacy” in the Prescription Drug Coverage section.

Spouse

A party who is of the opposite sex and legally married to the Employee under state law.

Total Disability or Totally Disabled

With respect to the Employee, the individual is prevented, solely by reason of Illness or Injury from engaging in such Employee's regular occupation and is performing no work of any kind for compensation or profit; or, with respect to a Dependent, the individual is prevented,

solely by reason of Illness or Injury, from engaging in substantially all of the normal activities of a person of similar age and gender in good health.

Unique Identification Number

The unique number assigned to the Employee and covered Dependents. This number appears on your insurance card.

USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994, and the regulations thereunder.

Usual and Customary Charge (U&C Charge)

The lowest of the following:

- The Allowable Charge; or
- Actual charges for the service or supplies.

Usual charge and maximum allowable charge, as stated above, are determined by using the criteria of the Claims Administrator as of the date of service.