

CITY OF CHICAGO GROUP
**HEALTH PLAN: MEDICAL PPO OPTION (“MEDICAL PPO
PLAN”) FOR POLICE**

Effective January 1, 2014

For sworn police officers below the rank of sergeant and represented by the Fraternal Order of Police.

Notice of Grandfathered Status

The City of Chicago believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted.

Being a grandfathered health plan means that the plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement to offer external review with respect to claims.

However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the U.S. Department of Health and Human Services at www.HealthCare.gov.

Notice of MHPAEA Opt-Out

The Plan is subject to the requirements of the Mental Health Parity and Addiction Equity Act of 2008 (the "MHPAEA"), effective January 1, 2014, unless it opts out of compliance.

The MHPAEA requires certain group health plans that provide both medical and surgical benefits and mental health or substance use disorder benefits to ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.

Group health plans sponsored by state and local governmental employers generally must comply with the MHPAEA. However, these employers that sponsor self-insured health plans are permitted to exempt the plan in whole or in part from the MHPAEA requirements. While the Plan generally complies with the bulk of the requirements under the MHPAEA, it does contain one mental health benefits restriction that would not be compliant. In order to preserve that restriction, the City has elected to exempt the Plan from coverage under the MHPAEA.

That non-conforming provision simply requires Plan Participants who receive outpatient mental health and substance abuse treatment by a behavioral health specialist to obtain pre-certification by a Medical Advisor, under the Plan's Medical Advisor Review Program, after the first seven sessions each year with one or more such providers. Because the City is opting out, this requirement will remain in place.

The City's election to opt out and exempt itself from the MHPAEA with respect to the Plan will be effective for the 2014 Plan Year beginning January 1, 2014, and ending December 31, 2014. The election may be renewed for subsequent Plan Years.

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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 page 90). 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. Under the City's group health plan, you have the option to select between an HMO option and a PPO option. This document provides information about the City's Medical PPO option for Police (the "Plan"). Additional information about other options under the group health plan 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, mental health and substance abuse treatment. 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 27). 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, 2014. 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 9.

II. QUICK GUIDE

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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 17-19 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 11.

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 13 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 get a divorce or if you and your Civil Union Spouse or Domestic Partner 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 Benefits Service Center 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 27. 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 (except those who are legally married in a state that recognizes such marriages – in which case, they would be simply considered “Spouses”) may not be eligible for continuation. See page 27 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 his/her behalf.

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 94. 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 coverage from the City during the leave under the same conditions as if they were working.

F. Military Leave

Under 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 27).

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; deductible does not include any Copayments; Out-of-Pocket Limit does not include Copayments.</i>		
Wellness Benefits		
<ul style="list-style-type: none"> - Routine Physical Checkups (Adults) - Routine Pediatric Checkups, Well Baby Care, Immunizations - Routine Lab Work - Hearing Screenings 	100% of Allowable Charges up to \$600 per covered individual, per year. Annual routine pap smear, mammogram, PSA and DRE are payable at 100% of the Allowable Charges, and do not apply toward the \$600 Wellness Benefit limit.	
Outpatient Medical Benefits		
- Office Visits	90%	60%
- Diagnostic Testing (e.g., X-ray, lab, etc.)	90%	60%
- Outpatient Surgery	90%	60%
- Physical Therapy	90%	60%
- MRI Scans, PET Scans, CAT Scans ⁽⁴⁾	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%
- Occupational and Speech Therapy ⁽²⁾	90%	60%
- Ambulance Transportation between Hospitals ⁽¹⁾	90%	90%
- Chiropractic office visits for manipulation (maximum 20 per year; three Modalities per visit)	90%	60%

Organ Transplants	PPO Provider	Non-PPO Provider
The following organ transplants are covered. You must call the Medical Advisor for Pre-Certification.		
- Heart ⁽¹⁾	90%	60%
- Combination Heart/Bilateral Lung ⁽¹⁾	90%	60%
- Simultaneous Pancreas Kidney ⁽¹⁾	90%	60%
- Kidney only in conjunction with SPK/PAK ⁽¹⁾	90%	60%
- Bone Marrow ⁽¹⁾	90%	60%
- Stem Cell (autologous and allogeneic) ⁽¹⁾	90%	60%
- Lung ⁽¹⁾	90%	60%
- Liver ⁽¹⁾	90%	60%
- Pancreas (PAK/PAT) ⁽¹⁾	90%	60%
- All Other Organ Transplants ⁽¹⁾	90%	60%
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 Provider	Non-PPO Provider
- Bariatric Surgery ⁽¹⁾	90%	60%
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; Deductible and Coinsurance apply.	
- Emergency Medical or Emergency Accident Care	90%	90%

Mental Health and Substance Abuse Treatment ³	PPO Provider	Non-PPO Provider
- Outpatient Mental Health and Substance Abuse ⁽³⁾ treatment by a Behavioral Health Specialist	90%	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) After 10 therapy visits, Pre-Certification by Medical Advisor is required. Call 1-800-373-3727. Speech and occupational therapy is only covered if it is for restoration of function; acquisition of function is not covered.
- (3) These services require Pre-Certification by Medical Advisor after the first seven sessions in any one year with one or more Providers.
- (4) Predetermination of medical necessity is highly recommended.

Prescription Drug Benefits

At a Participating Pharmacy:	Generic: \$10 copay
- Retail (Short term or maintenance medications)	Brand Name (Formulary) \$30 copay* Brand Name (Non-Formulary) \$45 copay*
- Mail Order (Maintenance/Long Term Medications for chronic conditions; 90 day supply)	Generic: \$20 copay Brand Name (Formulary) \$60 copay*

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

Important Note: Non-formulary drugs are not available through mail order. If there is no generic or alternative brand name formulary medication on the primary/preferred drug list, you may be able to purchase your medication through the mail order program.

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 the group health plan sponsored by the City, including under this Plan (the PPO Plan), and under 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 Benefits 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 (for mailing or hand-delivery of eligibility documents only)
Medical Plans				
PPO Plan Claims Administrator			1-800-772-6895	
Blue Advantage HMO	Blue Cross and Blue Shield of Illinois	www.bcbsil.com	1-800-730-8504 Fax: 1-918-551-2011	(For Claim Processing) 300 East Randolph Street Chicago, IL 60601-5099
Medical Plan Prescriptions				
PPO Plan Prescription Benefit Manager and Specialty Pharmacy	CVS Caremark	www.caremark.com	1-866-748-0028 Fax: 1-866-433-1172 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				
PPO Plan	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
Dental Plan				
Dental HMO	Blue Care Dental	www.bcbsil.com/cityofchicago	1-855-557-5487	(For Claim Processing) P.O. Box 23059 Belleville, IL 62223-0059
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
Health Spending Account	PayFlex (FSA)	www.healthhub.com	1-800-284-4885	Flex Dept. P.O. Box 3039 Omaha, NE 68103-3039

Term Life Insurance	Prudential Insurance Company of America	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.chicagodeferredcomp.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 Board	Policemen's Annuity and Benefit Fund of Chicago	www.chipabf.org	1-312-744-3891	221 N. LaSalle, Suite 1626 Chicago, IL 60601-1206
PHSA/COBRA Administrator	City of Chicago Benefits Service Center		1-877-288-5111	

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 (both of which are options offered under the City's group health 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 Plan if you are a full-time sworn police officer below the rank of sergeant and represented by the Fraternal Order of Police.

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

- A part-time Employee regularly scheduled to work less than 84 hours a month.

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 required 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 Division for a form),
- A certified civil union certificate (from any Illinois county clerk) within 60 days of the ceremony, AND

- *Statement of Tax Code Section 152 Dependence* (if you are claiming your Civil Union Spouse as a tax-qualified dependent as defined by Section 152 of the Internal Revenue Code (not applicable with respect to Civil Union Spouses who are legally married in a state that recognizes such marriages; such partners are considered to be Spouses).

Coverage for a Civil Union Spouse who is legally married to the Employee in a state that recognizes such marriages will terminate in the event of the Employee's death or divorce, but continuation coverage under PHSA COBRA will be available. However, coverage for any other Civil Union Spouse will terminate and continuation coverage benefits under PHSA COBRA will not be available 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 Tax Code Section 152 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 your same sex Civil Union Spouse is legally married to you in a state that recognizes such marriages or a Statement of Tax Code Section 152 Dependence has been submitted. There may be other tax consequences for the receipt of Domestic Partner or same sex Civil Union Spouse benefits (unless the same sex Civil Union Spouse is legally married to you); 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 online at www.cityofchicagobenefits.org or call the Benefits Service Center at 877-299-5111 within 30 days of his or her hire, 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 enrollment form and the documentation to establish eligibility can come in separately - each has a different due date, but both must be 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 option for the first 18 months of their employment, not the HMO option. 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 a 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 Plan Administrator 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. Payroll deductions will include an amount to pay for coverage retroactive to April 1 and going forward even though the first deduction actually may not occur until later. 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 online at www.cityofchicagobenefits.org, or by calling 877-299-5111. Required documentation for Dependents includes proof of dependency (as described on page 16).

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 online, 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.

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 online 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 Management Division 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 online 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. 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 paycheck. 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 and will be retroactive to the effective date of any change in coverage.

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 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 18.)

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,
- 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 22.) 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.

Continuing Coverage as an Inactive Employee

If you are covered by the Plan and a full-time law enforcement officer 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); or
- 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 or Occupational Disability benefits from the Police Pension Fund, 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 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 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 killed in the line of duty, 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

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.)

However, effective for plan years beginning on or after January 1, 2014, this Plan does not impose pre-existing condition exclusions.

PHSA COBRA Coverage

PHSA COBRA coverage may be available as described on page 27 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.org.

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

Qualifying Event Ending Coverage	Who May Continue (Qualified Beneficiaries)	Longest Period of Continuation
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.

Civil Union Spouses who are legally married to the Employee in a state that recognizes such marriages are considered to be Spouses and will be entitled to PHSA COBRA continuation coverage. 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 (such exclusions will not apply for plan years beginning on or after January 1, 2014); 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 Division and/or the Benefits Service Center 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 below 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 care 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)	Recommend 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 will:

- 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 10 visits in a Calendar Year – available for restoration of function only
 - 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;
 - 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 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.

We recommend that participants 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.

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.

Pregnancy Screening 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.

VIII. HOW THE MEDICAL PLAN WORKS

The City offers its Employees a choice of medical plan options, 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 option (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 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

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

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 20 chiropractic visits per year at 90%, after the Deductible is met, if performed by a PPO Provider, and at 60% of the Allowable Charge amount, after the deductible is met, if performed by a Non-PPO Provider. There is coverage for a maximum of 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.

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 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 Medical Advisor 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. Diagnostic testing 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.

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.

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 97. 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; or

- Surgical operations to reverse voluntary sterilization.
- 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 may 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 in order to avoid the \$1,000 penalty. 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.

A note about federal coverage requirements

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Physician (e.g., your Physician, Nurse, or certified nurse midwife, or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs (for example, to avoid the \$1,000 penalty referenced above), you may be required to obtain precertification or certification after-the-fact. For information on certification, contact your Plan Administrator.

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.

- Before treatment, you must call to precertify any alternatives to inpatient mental health and substance abuse treatments such as residential treatment centers, partial hospitalizations, and intensive/structured outpatient treatments.

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:

- 90% of Allowable Charges with respect to PPO 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 90% of Allowable Charges after the Deductible is met. 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 malerupted 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 90% of Allowable Charges, after the Deductible. 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 (and, with respect to emergency room treatment, after the \$100 copayment). 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 to restore function. There is no coverage, however, for speech or occupational therapy that is to acquire function or which is administered merely to maintain a level of function where there is no expectation of demonstrable and measurable improvement. Outpatient speech and outpatient occupational therapy will only be covered if it restores function previously present in a person who had fully developed skills that were lost due to an injury or an illness. Speech therapy or occupational therapy to acquire function or to maintain a level of functioning for a covered person who has not previously reached the level of intellectual, speech, motor or physical development normally expected for the covered person's age is **not** covered. Up to 10 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 10 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 90% for PPO Provider services and 60% for Non-PPO Provider services after the deductible is met.. 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. 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 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.

Preventive Services

The Plan pays 100% of the Allowable Charge up to \$600.00, per covered Participant per year for preventive services. Preventive services include such services as routine physical checkups for adults, routine pediatric checkups, immunizations, routine lab work, and hearing

screenings. The preventive services must be provided by a covered Provider and are subject to the frequency, gender, and age guidelines established under the “USPSTF” guidelines. Notwithstanding the preceding, annual routine pap smear, mammogram, PSA, and DRE are payable at 100% of the Allowable Charge and do not count towards the \$600 preventive services limit.

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. Benefits will not be paid if the Medical Advisor determines that the services are not Medically Necessary. 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.

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, during the appeal, 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.

Wellness Benefits

See Preventive Services above.

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 in-patient if pre-certified as set forth in the Medical Advisor Review Program.
- **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** of the eye (i.e., nearsightedness or farsightedness).
- **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.
- Treatment or classes for **smoking cessation**, including patches, hypnotism, etc.
- **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 95 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 medications or devices used for **contraceptive** purposes.
- Charges for **chiropractic** visits in excess of 20 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.
- **Private duty nursing**.
- 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 drug.

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;

- 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: See also the Schedule of Benefits in Article IV.

At a Participating Pharmacy:	Generic: \$10 copay
- Retail (Short term or maintenance medications)	Brand Name (Formulary) \$30 copay* Brand Name (Non-Formulary) \$45 copay*
- Mail Order (Long-term medications for chronic conditions; 90 day supply)	Generic: \$20 copay Brand Name (Formulary) \$60 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.	
<i>Important Note: Non-formulary drugs are not available through mail order. If there is no generic or alternative brand name formulary medication on the primary/preferred drug list, you may be able to purchase your medication through the mail order program.</i>	

The Copayments for Prescription Drugs do not count towards any Deductible or Out-of-Pocket Limit.

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 fill at a pharmacy that is not participating in the network. 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.
- 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.
- Benefits will not be provided for any refills if the prescription is more than one year old.

Prior Authorization Regarding Prescription Coverage

- 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 contraceptives used for non-contraceptive purposes (there is no coverage for contraceptives otherwise), human growth hormone and all specialty drugs available from the Specialty Pharmacy, such as Humira Pen, Gleevac, 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.

Review of Prescription Drug Data

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 also will review medical and prescription data from time to time to determine if the prescription drug dispensing activity is within established limits.

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.
- Contraceptives.
- Non-prescription drugs and vitamins.
- Immunizations and inoculations (except to the extent covered by the wellness benefit described on page 53).
- Drugs that are considered Experimental by generally accepted medical practice standards.
- Drugs for smoking cessation.
- 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 54) for general exclusions regarding benefits as they also apply to the Prescription Drug program.

XIII. CLAIM FILING AND APPEAL 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.*

This section includes information on how to file a claim, how to appeal a claim if a claim is denied in whole or in part, how quickly a claim must be filed, how the Plan will recover claims paid on behalf of third or other parties, and how a claim will be paid if a Participant is covered by more than one medical plan.

Claim Filing and Determination

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

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 your 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.

Eligibility and 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.

Payment of Claims and Assignment of Benefits

Under this Plan, the 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 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.

However, 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 Claims Administrator itself undertakes to furnish health care services, but solely to make payments to Providers for Covered Expenses incurred by you. Neither the Claims Administrator nor the City are in any event 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 only be legally performed by a Provider are not provided by the Claims Administrator nor the City. Any contractual relationship between the Claims Administrator and a Provider is not construed to mean that the Claims Administrator is providing professional service.

The use of an adjective such as "participating," "preferred" or "network" in describing a Provider in no way should be construed as a recommendation, referral, or any other statement as to the ability or quality of the Provider. In addition, the omission, non-use, or non-designation of these adjectives or of any similar description (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.

Providing Notices

Any information or notice that must be furnished to the Claims Administrator under the Plan as described in this PPO booklet must be in writing and sent to the Claims Administrator at the address indicated in the Important Contact Information Section. Any information or notice which the Claims Administrator furnishes to you must be in writing and sent to you at your address as it appears on the Claims Administrator's records and if applicable, in the case of a National Medical Support Order, to the designated representative as it appears on the Claims Administrator's records.

Time Limits for Filing Claims

Claims must be submitted to the Claims Administrator for processing within two years of the date the service is rendered to be considered. Claims for medical benefits should be sent directly to the Claims Administrator. Claims for prescription drug benefits should be sent to the Prescription Manager. Do not send bills or claims to the Benefits Service Center.

Information and Records

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

In addition, the Claims Administrator may furnish similar information and records (or copies of records), in accordance with HIPAA (see page 80), 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, termination of Medicare eligibility, or any changes in Medicare eligibility status so that the Claims Administrator may be able to make claim payments in accordance with applicable laws.

If a Claim is Denied

If all or part of your claim is denied, you have the right to request a review of the decision by sending a written request for review within 90 days after notification of the denial to the Claims Administrator at the address indicated in the Important Contact Information Section.

If you are not satisfied with the decision of the Claims Administrator, you can then appeal the decision by sending a written request for review to the Benefits Manager. All disputes regarding claim denials must be delivered via hand-delivery or mailed to the Benefits Manager at the address listed below within 30 days of the denial of the appeal by the Claims Administrator.

If the Benefits Manager, or his or her designated representative, determines that you are not eligible to participate in the Plan or are otherwise not entitled to benefits, you will be notified of a denial after the determination. A written notice will be provided and will include the reason for the denial and a statement of the right to appeal the denial 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.

Discretion of the Benefits Committee

The Benefits Committee has complete discretion to interpret the terms of the City's self-funded Plans as applied to individual claims, and no benefits will be paid unless the Benefits Committee or its authorized representative (i.e., the Claims Administrator) has determined in its sole discretion that a claimant is entitled to them.

XIV. 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 the 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.

XV. 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. However, the maximum amount payable by this Plan is limited to the amount that would have been paid if there were no other plans involved. 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, and Coinsurance, 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 70.

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 80, 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.

XVI. 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.

XVII. 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.

XVIII. 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. Neither the Benefits Management Division nor its Service Center stores 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.

XIX. 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 and Civil Union Spouses generally 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. That said, Civil Union Spouses who have been legally married in a state that recognizes such marriages are Spouses and thus will be considered tax-qualified dependents for this purpose.

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 Section 5.5 of 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.

The following information applies to all Employees eligible under this Plan. 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 (effective 7/1/06) 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

The following examples are provided to clarify the payroll deductions (2006 rates are used for illustrative purposes):

<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 = \$24.77</p> <p>Employee + 1: \$46,000 x .019854 divided by 24 = \$38.05</p> <p>Family: \$46,000 x .024765 divided by 24 = \$47.47</p> <p>These calculations are applicable 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>	

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.

XX. 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.

XXI. 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.

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 information regarding the claim. 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.

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.

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 Section IV.

Copayment

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 40, 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 11 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 39. 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

A duly licensed institution for the care of the sick that provides services under the care of a Physician including the regular provision of bedside nursing by registered nurses. A hospital does not mean health resorts, rest homes, nursing home, skilled nursing facilities, convalescent homes, custodial homes of the aged, or similar institutions.

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 32.

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, services or equipment that is 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 a lesser setting such as but not limited to the Doctor's office, a free standing or hospital based ambulatory setting, 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 any Inpatient setting including acute Hospital, Skilled Nursing Facility, nursing home, subacute or acute rehab facility, long-term acute care Hospital (LTACH), 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 on either an intermittent or shift basis (private duty nursing) to provide custodial care, that would include the following: to provide care that could be reasonably taught to a lay caregiver, 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.
- Treatment performed by a Professional Provider who is not licensed at a level appropriate to the type of care required.

Refer to the Medical Plan Exclusions section on page 54 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; and
- 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 11.

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

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.

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.

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 person who is legally married to the Employee under state the laws of any state or foreign nation.

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.

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.

USERRA

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