AMENDMENT TO THE
CITY OF CHICAGO MEDICAL PPO PLAN
(EFFECTIVE JANUARY 1, 2022, OR AS OTHERWISE SPECIFIED BELOW)

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

(As amended and restated effective as of October 1, 2015)

This Amendment to the Plan, as amended and restated effective as of October 1, 2015, (herein the "Plan") is adopted effective as of January 1, 2022, unless another date is specified below. Except as amended, the Plan shall continue in full force and effect in accordance with its terms.

1. **Over-the-Counter COVID Tests:** Effective January 15, 2022, coverage for COVID-19 testing includes coverage for over-the-counter at-home diagnostic COVID-19 test kits. Coverage will be limited to up to 8 tests for each Employee and Dependent covered under the Plan every 30 days without prior authorization requirements.

   If at-home tests are purchased at most pharmacies in the CVS Caremark network or through the Caremark mail order program, the tests will be covered at 100% without cost sharing. If tests are purchased at a non-network pharmacy (or at a network pharmacy that is not participating in CVS Caremark's direct coverage program), the Employee or Dependent will be eligible to receive a maximum reimbursement of $12 per test.

   Tests must be purchased for personal use only and may not be resold.

2. **Ancillary Services:** A new definition is added as follows:

   Ancillary Services

   Emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and

laboratory services; and items and services provided by a Non-PPO Professional Provider if there is no PPO Provider who can furnish such item or service at such facility.

3. **Network Administrator:** The definition of "Claims Administrator" is revised to refer to "Claims Administrator or Network Administrator" so that the two terms are used interchangeably to refer to Blue Cross Blue Shield of Illinois.

4. **Emergency Medical Condition:** The definition of "Emergency" is revised to refer to "Emergency/Emergency Medical Condition" such that the two terms may be used interchangeably.

5. **Emergency Services Definition:** The definition of "Emergency Care" and all uses thereof in the Plan are replaced as follows:

   Emergency Services

   Outpatient and inpatient services provided with respect to an Emergency Medical Condition, including treatment provided by and within the capabilities of the emergency department of a Hospital (including a Hospital outpatient department) or an independent, freestanding emergency department that is geographically separate and licensed separately from a Hospital under applicable state law, including an appropriate medical screening examination and ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition and medical treatment necessary to stabilize the person (in other words, to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the person from the facility). Emergency Services include treatment of an Emergency Medical Condition by an urgent care facility if such facility is permitted by applicable state licensure laws to provide such services.

6. **Non-PPO Providers:** The definition of Non-PPO Providers is revised to read as follows:

   Non-PPO Providers

   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 "Allowable Charge"), they may "balance bill" the Participant for the difference between what the Plan pays them and their full charges, unless balance billing is prohibited by law. (Note: Non-PPO Providers are considered Tier 3 Providers.)

7. **Out-of-Network Rate:** A new definition is added as follows:

Out-of-Network Rate

An (i) amount determined by an applicable All-Payer Model Agreement under the Social Security Act, or, (ii) if there is no such applicable agreement, an amount determined by applicable state law, or (iii) if there is no such agreement and no amount determined by state law, the payment amount agreed to by the Plan and the provider or facility, or (iv) if none of the above conditions apply, the amount determined through an independent dispute resolution process.

8. **Recognized Amount:** A new definition is added as follows:

   Recognized Amount

   An (i) amount determined by an applicable All-Payer Model Agreement under the Social Security Act, or, (ii) if there is no such applicable agreement, an amount determined by applicable state law, or (iii) if there is no such agreement and no amount determined by state law, the lesser of the billed amount or the median in-network rate recognized by the Plan for the respective services as of January 31, 2019, indexed for inflation thereafter.

9. **Balance Billing by Non-PPO Providers:** Generally, Non-PPO Providers may balance bill Participants for the difference between the Allowable Charge and the billed amount. The Plan will not pay these amounts, and such charges do not count towards satisfaction of the Deductible or Out-of-Pocket Limit – rather, it is your responsibility to pay these excess amounts. Notwithstanding the preceding, Non-PPO Providers of Emergency Services and certain Non-PPO Providers performing services at PPO facilities are legally restricted in their ability to balance bill for charges above legally determined amounts. You will receive more information as to these restrictions in the explanation of benefits with respect to relevant claims.

10. **Coverage for Emergency Services:** The Plan covers Emergency Services provided by both PPO and Non-PPO Providers at 90% (the Tier 1 Coinsurance rate) of the Out-of-Network Rate after payment of an Emergency Room Copayment of $200 per visit (which is waived if you are ultimately admitted as in-patient). The Copayment does not apply to your Deductible, but it does apply to the Tier 1 PPO Provider Out-of-Pocket Limit (regardless of whether the services are provided by a Tier 1 or Tier 2 PPO or Non-PPO Provider). Your 10% Coinsurance responsibility with respect to Emergency Services received from a Non-PPO Provider will be based on the Recognized Amount.

    Post-stabilization services provided by Non-PPO Providers will be considered Emergency Services for purposes of applying the payment rules with respect to Emergency Services unless certain conditions are met. Post-stabilization services include Outpatient observation and Inpatient or Outpatient stays with respect to the

visit in which other Emergency Services are furnished.

Post-stabilization services from a Non-PPO Provider are not considered Emergency Services for payment purposes if (i) the attending emergency Physician or treating provider determines that the patient is able to travel using nonmedical transportation or nonemergency medical transportation to an available PPO Provider located within a reasonable travel distance, taking into consideration the individual's medical condition, (ii) the Non-PPO Provider furnishing such services provides adequate notice as to non-network billing practices to the patient as required by federal law and receives informed consent from the patient to continued treatment despite the greater cost, in compliance with applicable law.

11. **Air Ambulance Coverage:** Covered Expenses for Medically Necessary air ambulance (medical transport by fixed wing airplane or rotary wing helicopter) services shall be paid at 90% regardless of whether the provider is a PPO Provider or Non-PPO Provider, and your 10% Coinsurance responsibility will be calculated based on the lesser of the billed amount for the services of the median of the Network Administrator's contracted rates with participating providers in the geographic region for the respective services as of January 31, 2019, indexed for inflation thereafter, and any Coinsurance payments you make with respect to covered air ambulance services will count toward the Tier 1 PPO Deductible and Out-of-Pocket Limit, regardless of whether received from a Tier 1 or Tier 2 PPO or non-PPO Provider.

12. **Non-Emergency Treatment by a Non-PPO (Tier 3) Provider at a Tier 1 or 2 Facility or a Tier 2 PPO Provider at a Tier 1 Facility:** Covered Expenses for Medically Necessary non-Emergency treatment by a Non-PPO Professional Provider at a Tier 1 or Tier 2 Hospital or other facility or by a Tier 2 Professional Provider at a Tier 1 Hospital or other facility will be paid with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a Professional Provider in the same Tier as the Hospital or other facility. In other words, the Coinsurance percentage and any Copayments applicable to such services will be the same as if the services were furnished by a Professional provider in the same tier as the Hospital or other facility.

    Your Coinsurance responsibility will be based on the Recognized Amount, and any Co-payments or Coinsurance that you pay with respect to covered non-Emergency services will count towards the Deductible and Out-of-Pocket Limit applicable to the Tier of the Hospital or other facility. In other words, if the Hospital is in Tier 1, then your cost sharing will be determined according to the Tier 1 Schedule of Benefits, and if the Hospital is in Tier 2, then your cost sharing will be determined according to the Tier 2 Schedule of Benefits, regardless of the Provider's tier.

    An exception will apply with respect to certain Non-PPO Providers who have provided you notice and receive your informed consent with respect to out-of-network billing practices in compliance with applicable law. If the exception applies, the applicable Non-PPO Coinsurance percentage to be paid by the Plan will be based on the Allowable

Charge, and the Non-PPO Deductible and Out-of-Pocket Maximum will apply. No exception is available, however, with respect to providers of Ancillary Services or with respect to items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or services is furnished, regardless of whether the notice and consent requirements have been satisfied.

13. **Continuity of Care:** If a provider or facility ceases to be a PPO Provider due to termination of the provider or facility's contractual relationship with the Plan's Network Administrator, a "continuing care patient" may elect continued transitional care for a 90-day period from such provider or facility with benefits paid on the same terms and conditions under the Plan as if the provider or facility had remained in-network. This will allow you time to transition your care to a PPO provider.

    An individual is a continuing care patient if the individual (a) is undergoing a course of treatment for a "serious and complex condition" from the provider or facility; (b) is undergoing a course of institutional or Inpatient care from the provider or facility; (c) is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery; (d) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or (e) is or was determined to be "terminally ill" and is receiving treatment for such illness from such provider or facility.

    An individual has a serious and complex condition if the individual has a condition that (a) in the case of an acute Illness, is a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (b) in the case of a chronic illness or condition, is a condition that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time. An individual is terminally ill if the individual has a medical prognosis that the individual's life expectancy is six months or less.

    If you are a continuing care patient entitled to elect continued transitional care as described herein, you will be timely notified by the Network Administrator.

14. **Services or Supplies Obtained from Non-PPO Provider or Tier 2 PPO Provider Believed to be PPO Provider or a Tier 1 PPO Provider, Respectively:** If you receive information through the public website database or provider directory made available by the Network Administrator, or in response to a direct request for information, indicating that a provider is either a Tier 2 or Tier 1 PPO , and, in reliance upon such information, you obtain supplies or services from a Non-PPO Provider or from a Tier 2 PPO Provider in the belief that the Provider is either a Tier 2 or Tier 1 PPO Provider, respectively, benefits will be paid as if the provider were, in fact, in-network in Tier 2 or 1, respectively, subject to application of the Tier 2 or Tier 1 (as applicable) PPO Coinsurance, Co-payments, Deductibles, and Out-of-Pocket Limits. In other words, your claims will be paid as if the Provider were in the Tier that was communicated to you via the website database or provider directory or in response to a direct request.