

City of Chicago

Retiree Healthcare Plans Effective July 1, 2013

**Non-Medicare Eligible Retiree
Healthcare Plan**

**Medicare Supplement Retiree
Healthcare Plan**

Plans Effective as of July 1, 2013

Introduction

How to Use this Retiree Benefit Booklet

Please read this entire *Retiree Benefit Booklet* at least once. It will help you to be generally familiar with the Plans and what they cover. If you know the rules and follow them, you may be able to reduce your out-of-pocket cost for health care. Following this page is a list of typical questions about the Plans and where to find answers to those questions, called a *Quick Guide to this Retiree Benefit Booklet*. It is not intended to be a substitute for reading the *Retiree Benefit Booklet* – it is intended to help you locate answers to your most important questions quickly.

The retiree health benefits described in this document are being offered by the City of Chicago (the “Plan Sponsor”) to certain retirees and their eligible dependents as set forth herein.

There are two Retiree Plans (referenced collectively as the “Plans” or “Plan” or individually as “Plan”), one for those who are eligible for Medicare as their primary coverage (“Medicare Supplement Retiree Healthcare Plan”) and one for those who are not eligible for Medicare as their primary coverage (“Non-Medicare Eligible Retiree Healthcare Plan”). The Plans cover medical expenses in different ways and there are separate sections that describe how medical claims will be paid under the Medicare Supplement Retiree Healthcare Plan provisions and under the Non-Medicare Eligible Retiree Healthcare Plan provisions. The Plans are effective as of July 1, 2013. For information regarding the City’s right to amend or terminate the Plans, please see the provisions in *Amendment and Termination of Plans* beginning on page 105. **As a general matter, with respect to Retirees who retired before August 23, 1989, the City will continue to offer the Plans indefinitely. With respect to Retirees who retired on or after August 23, 1989, the City will continue to offer the Plans through December 31, 2016. Additionally, with respect to either group of Retirees, the City may modify the benefits in any way for any reason at any time in its sole discretion. This includes for example, but is not limited to, changes to Deductibles, out-of-pocket expense limitations, copayments and co-insurance.**

Prescription Drugs are covered by both Plans in the same way, so the *Prescription Drug Program* section beginning on page 78 of this *Retiree Benefit Booklet* applies to both Medicare Supplement and Non-Medicare Eligible Retiree Healthcare Plan Covered Persons. Since the same terms apply to both the Medicare Supplement Retiree Healthcare Plan and the Non-Medicare Eligible Retiree Healthcare Plan, it is presented only once but should be considered as included in the medical expense section for each Plan.

Similarly, certain other rules apply to both Medicare Supplement and Non-Medicare Eligible Retiree Healthcare Plan Covered Persons. For example, enrollment, claim filing, claim appeal processing, and the determination of monthly contribution rates are the same for all Covered Persons. These and similar items are discussed only once in this *Retiree Benefit Booklet* but should be considered as included in each Plan.

In addition, the people who can provide information to you about the Plans and answer questions are the same for both Plans. There is a list of Important Contacts provided with the *Retiree Benefit Booklet*. Monthly contribution rates and the City’s share of the costs of providing these benefits will change as determined in the City’s sole discretion. You will be notified about contribution rates and any changes thereto as well as any changes to this document as they occur.

It is important that you keep the Plan Administrator (the City of Chicago, also sometimes referenced simply as the “City”) and your Pension Fund informed about changes in your status or in the status of a Spouse or dependent that is covered by the Plan. For example, you must notify the Plan about address

changes, becoming Medicare Eligible, a change in a dependent's status or the death or divorce of a Spouse. Keep in mind that any 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. Note: It may cost you money if you do not notify the City **and** the applicable Fund about these kinds of changes. In addition, 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 *Continuing Medical Coverage under PHS* beginning on page 31). In addition, if you deliberately defraud or mislead the Plan Administrator about the eligibility of yourself or your dependents, you and your dependents will become ineligible for benefits effective immediately.

The City of Chicago has full discretion to interpret and apply the terms of the Plans. The City also has the right to waive enforcement of the terms of the Plans including for purposes of settling claims and disputes.

Following the *Quick Guide to this Retiree Benefit Booklet* section, this *Retiree Benefit Booklet* summarizes the major features of the benefit coverage. The first of the summaries is for the Non-Medicare Eligible Retiree Healthcare Plan and the second is for the Medicare Supplement Retiree Healthcare Plan. They, too, include page number references so that you can locate the information quickly. Following those pages are an index to the rest of the document and the details of the Plans.

The order of topics covered in this *Retiree Benefit Booklet* is as set forth here. All of the following sections apply to both Plans (*unless otherwise specified*):

How to use this Retiree Benefit Booklet.

Table of contents.

Important contact information.

Definitions.

Eligibility, enrollment, and termination of coverage.

Non-Medicare Eligible Retiree Healthcare Plan Benefit information (Non-Medicare Eligible Individuals only).

Medicare Supplement Retiree Healthcare Plan Benefit information (Medicare Eligible Individuals only).

Prescription drug program information.

Exclusions, which describe what is not covered by the Plans.

Claim filing and appeal instructions.

Means Test information.

Amendment and termination of Plans.

HIPAA information.

Quick Guide to this Retiree Benefit Booklet

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What does the Plan cover (the big picture)?	See page 35	See page 64
How does the Plan cover Prescription Drugs?	See page 78	See page 78
How does the Plan cover Hospital stays?	See page 49	See page 70
How does the Plan cover Outpatient Hospital expenses?	See page 51	See page 72
How does the Plan cover Skilled Nursing Facility expenses?	See page 58	See page 72
How does the Plan cover doctor expenses?	See page 53	See page 72
How does the Plan cover Durable Medical Equipment?	See page 59	See page 74
Do I have to call anyone before I seek medical services?	See page 43	See page 70
What does Medicare pay?	Does not apply	See page 68
What happens when I become eligible for Medicare?	See page 27	See page 27
How are Physical, Occupational, and Speech Therapy covered?	See page 61	See page 73
How are other medical expenses covered?	See page 56	See page 73
How do I file a claim?	See page 92	See page 92
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Who must I notify about changes in my life?	See page 27 information	See page 27 information
What does coverage cost?	You will be notified annually as to coverage costs	You will be notified annually as to coverage costs
Who can answer questions on Plan coverage?	See <i>Important Contacts</i>	See <i>Important Contacts</i>

If I want to know. . .	I am not eligible for Medicare:	I am eligible for Medicare:
Who can answer questions on enrollment and eligibility?	See page 21 and <i>Important Contacts</i>	See page 21 and <i>Important Contacts</i>
Who can answer questions on the claim appeal process?	See page 92 and <i>Important Contacts</i>	See page 92 and <i>Important Contacts</i>

If I want to know. . .	I am not eligible for Medicare:	I am eligible for Medicare:
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Important Contact Information

Below is contact information for the various organizations that provide services under the Plan. Contact information also will be available at www.cityofchicagobenefits.org.

IMPORTANT WEB SITES, TELEPHONE NUMBERS, AND ADDRESSES				
Service	Provider	Website	Telephone	Address
Plan Eligibility and Enrollment Documentation	City of Chicago Benefits Service Center Benefits Management Division	www.cityofchicagobenefits.org	1-877-288-5111	333 S. State Street, Room 400 Chicago, IL 60604-3978
Claim Administrator & Network Administrator	Blue Cross and Blue Shield of Illinois	www.bcbsil.com	1-800-772-6895 For PPO network providers outside of the Chicago area: 1-800-810-BLUE	(For Claim Processing) 300 East Randolph Street Chicago, IL 60601-5099
Medical Advisor	Telligen	www.telligen.qualitrac.com	1-800-373-3727	1776 Westlakes Parkway West Des Moines, IA 50266-7771
Pharmacy Benefit Manager and Specialty Pharmacy	CVS Caremark	www.caremark.com	1-866-748-0028	(For mail order prescriptions) P.O. Box 94467 Palatine, IL 6094- 4467 (For paper claims) P.O. Box 52196 Phoenix, AZ 85072-2196
Pension Funds				
Uniformed Firefighters	Firemen's Annuity and Benefit Fund of Chicago	www.fabf.org	1-312-726-5823	20 S. Clark, Room 1400 Chicago, IL 60603-1899
Sworn Police	Policemen's Annuity and Benefit Fund of Chicago	www.chipabf.org	1-312-744-3891	221 N. LaSalle, Suite 1626 Chicago, IL 60601-1206
Municipal Employees	Municipal Employees and Annuity and Benefit Fund of Chicago (M.E.A./B.F.C.)	www.meabf.org	1-312-236-4700	321 N. Clark St., Suite 700 Chicago, IL 60654-4767

IMPORTANT WEB SITES, TELEPHONE NUMBERS, AND ADDRESSES

Laborer Employees	Laborers and Retirement Board Employee Annuity Benefit Fund of Chicago	www.labfchicago.org	1-312-236-2065	321 N. Clark St., Suite 1300 Chicago, IL 60654-4767
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Definitions

This Section Applies to Both Plans

Throughout this *Retiree Benefit 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 *Retiree Benefit 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 *Retiree Benefit Booklet*.

Accidental Injury

A severe injury, not intentionally self-imposed, that requires immediate attention by a Physician.

Administrator Provider

A Provider that has a written agreement with the Claim Administrator or a PPO network plan to provide services to you at the time services are rendered to you.

Ambulance Transportation

Medically Necessary local transportation to receive Emergency Medical Care in a specially equipped certified vehicle from home, the scene of an accident or a medical emergency to a Hospital, between one Hospital and another Hospital if it is Medically Necessary that the patient be transferred, or between a Hospital and a Skilled Nursing Facility. 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 services.

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.

Annuity Start Date

The starting date of the annuity, that is, the first day of the month for which the Retiree, Surviving Spouse Annuitant, or Child Annuitant received a payment from a Pension Fund based on service with the City of Chicago.

Benefit Period

A period of one year, beginning on January 1 of each year and ending December 31st. For those enrolling for the first time, the first Benefit Period begins on the Coverage Date and ends on December 31 of the same calendar year.

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.

Certified by the Medical Advisor

In some instances, the Covered Person must contact the Medical Advisor in advance of receiving care. Refer to the *Medical Advisor Review Program* section beginning on page 43 and certain Medicare Supplement provisions beginning on page 64. 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 approved (if required) the treatment or services, the treatment or services are considered to have been “Certified by the Medical Advisor.”

Chemotherapy

The treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.

Child Annuitant

A person receiving an annuity from one of the City’s four Pension Funds who is entitled to that annuity based solely upon a deceased parent’s City of Chicago employment.

Chiropractor

A duly licensed chiropractor.

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 Retiree.

Claim

Notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to the ,Surviving Spouse Annuitant, Child Annuitant, or other Covered Person. This notification must include full details of the service received, including name, age, sex, identification

number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information that the Claim Administrator may request in connection with services rendered.

Claim 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 Claim Administrator is identified in the Important Contact Information Section.

Claim Charge

The amount that appears on a Claim as the Provider's charge for service rendered. For Providers that have contracted or made special arrangements to provide discounts under this Plan, the Claim Charge means the discounted amount of the claim.

Claim Payment

The benefit payment calculated by the Claim Administrator, after submission of a Claim, in accordance with the benefits described in this benefit ***Retiree Benefit Booklet***. All Claim Payments will be calculated based on the Eligible Charge for Covered Services rendered.

Clinical Laboratory

A clinical laboratory that complies with the licensing and certification requirements under the Clinical Laboratory Improvement Amendments of 1988, the Medicare and Medicaid programs, and any applicable state and local statutes and regulations.

Clinical Professional Counselor

A duly licensed clinical professional counselor.

Clinical Social Worker

A duly licensed clinical social worker.

Coinsurance

A percentage of an eligible expense that Covered Persons are required to pay toward a Covered Service.

Congenital Anomaly

A physiological or structural abnormality that develops before birth and is present at the time of birth, for example, as a result of faulty development, infection, heredity, or injury.

Contracted Cost

The price that the Pharmacy Benefit Manager and the City have contracted for as the cost for a covered prescription provided to a Covered Person under this Plan.

Co-Payment

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

Course of Treatment

Any number of procedures or treatments performed by a Provider in a planned series resulting from an examination in which the need for such procedures or treatments was determined.

Coverage Date

The date on which a Covered Person's coverage under the Plan begins.

Covered Person

Those persons who are both eligible for and enrolled in either of the Retiree Health Plans.

Covered Service

A service or supply specified in this benefit *Retiree Benefit Booklet* for which benefits will be provided.

Certified Registered Nurse Anesthetist (CRNA)

A Certified Registered Nurse Anesthetist, who:

Is a graduate of an approved school of nursing and is duly licensed as a registered nurse;

Is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors;

Has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and

Is recertified every two years by the Council on Recertification of Nurse Anesthetists.

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 Claim Administrator’s medical staff and/or the Medical Service Advisor program determine what services are considered Custodial Care for the Non-Medicare Eligible Retiree Healthcare Plan. They also review when Medicare benefits have been exhausted with respect to days of Inpatient care. For the Medicare Supplement Retiree Healthcare Plan, the Medicare law and regulations (as interpreted by the Centers for Medicare and Medicaid Services) determine what constitutes “Custodial Care” under Medicare, and that determination also applies to the Plan’s supplemental provisions.

Deductible

The amount of Eligible Charges a Covered Person must pay each calendar year from his/her own pocket before benefits are paid by the Plan. There is no carryover provision.

Diagnostic Service

Tests rendered for the diagnosis of your symptoms and that are directed toward evaluation or assessment of progress of a condition, disease, or injury. Such tests include, but are not limited to, x-rays, pathology services, Clinical Laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, and electromyograms.

Domestic Partner

A qualified domestic partner within the meaning of, and who has satisfied the requirements of, City of Chicago Municipal Code Section 2-252-072, and who was an enrolled domestic partner health benefit dependent of a City of Chicago employee on the last day of the employee’s active employment.

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 a disease 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 a disease 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.

Eligible Charge

For Providers Other than Professional Providers (for example, Hospitals) In the case of a Provider that has a written agreement with the Claim Administrator to provide care to a Covered Person at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services.

In the case of a Provider that does not have a written agreement with the Claim Administrator to provide care at the time Covered Services are rendered, the Eligible Charge will be the lesser of the Provider's billed charges or an amount determined by the Claim Administrator which currently is developed from the rate of base Medicare reimbursements and represents approximately 100% of the base Medicare rate and excludes any Medicare adjustment(s) based on claim information. For out of network coordinated home care services, the Eligible 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 alter the Eligible 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).

For Professional Providers

The lesser of the PPO Provider's actual billed charge or the amount determined by the Claim 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 Eligible Charge. These amounts may be amended from time to time by the Claim 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 Provider claims. The application of these rules or edits may result in an adjustment to the Eligible Charge for any particular service. In the event the Claim Administrator does not have any rules or edits for a particular service, the Claim 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).

Eligible Person

A person meeting the eligibility requirements to receive benefits under the Plans, as described in the *Eligibility, Enrollment, and Termination of Coverage* of this ***Retiree Benefit Booklet*** as set forth beginning on page 21.

Emergency Hospital Admission

Any Hospital admission for which a patient has 24 hours or less advance notice, and the illness or injury is so acute in nature and of such severity that it constitutes an extremely hazardous medical condition that would result in jeopardy to the patient’s life or cause serious harm to the patient’s health if not treated immediately.

Emergency Medical Care

Services provided for the initial Outpatient treatment, including related Diagnostic Services, of the sudden and unexpected onset of a medical condition or to treat Accidental Injuries where the absence of immediate medical attention would likely result in serious and permanent medical consequences. Examples of medical conditions requiring immediate medical attention are severe chest pains, convulsions, or persistent, severe abdominal pains.

Experimental or Investigational or Investigational Services and Supplies

Treatment considered experimental or investigational 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

- Specifically with regard to drugs, combinations of drugs and/or devices that do not receive final approval from 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.

Fund or Pension Fund

Any one of the following Pension Funds sponsored by the City of Chicago (referenced collectively as the “Funds,” or individually as a “Fund”):

The Policemen’s Annuity and Benefit Fund of Chicago,

The Municipal Employees’, Officers’ and Officials’ Annuity and Benefit Fund of Chicago;

The Firemen’s Annuity and Benefit Fund of Chicago; and

The Laborers’ and Retirement Board Employees’ Annuity and Benefit Fund of Chicago.

Home 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 Covered Person must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and must require Skilled Nursing Service on an intermittent basis under the direction of a Physician. This program includes, among other things, Skilled Nursing Service by or under the direction of, a registered professional nurse, and the services of 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. For the Medicare Supplement Retiree Healthcare Plan, the agency must be certified by Medicare and the services must be paid by Medicare as the primary payer.

Hospice Care Program Provider

An organization duly licensed to provide Hospice Care Program Service.

Hospice Care Program Service

A centrally administered program designed to provide for the physical, psychological, and spiritual care for dying persons (i.e. individuals with a terminal disease and a life expectancy of less than six months) and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility or in a special hospice care unit of a Hospital.

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.

Participating Hospital: A Hospital that has a written agreement with the Claim Administrator to participate in the PPO network.

Non-Participating Hospital: A Hospital that does not meet the definition of a Participating Hospital.

Inpatient

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

Last Day of Active Employment

The last day of active employment with the City.

Mail Order Prescription Drug Program

The program service that provides Prescription Drugs through the mail pursuant to the rules of Pharmacy Benefit Manager that has contracted with the Plan Administrator at the time the prescription is filled.

Maintenance Occupational Therapy, Maintenance Physical Therapy, and/or Maintenance Speech Therapy

Therapy administered to maintain a level of function from which no demonstrable and measurable improvement of a condition will occur.

Maintenance Prescription Drugs

Prescription Drugs that are used on a continual basis for the treatment of a chronic health condition.

Maximum Allowance

The amount determined by the Claim Administrator that Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Professional Providers, whether Participating or Non-Participating, will be based on the Schedule of Maximum Allowances. These amounts may be amended from time to time by the Claim Administrator. In addition, if a Participating Professional Provider submits a charge that is less than the Maximum Allowance, the Provider will be paid based on the amount of the actual charge.

Medical Advisor

A health care professional employed by the Plans to review Hospital confinements, explain alternatives to Hospital care and facilitate the early discharge of a Hospital patient. The Medical Advisor also makes recommendations about the Medical Necessity of treatments and services to the Claim Administrator.

Medical Care

The ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an illness or injury.

Medically Necessary or Medical Necessity

See also the Exclusions: What is Not Covered by the Plans section on page 87 of this ***Retiree Benefit Booklet***.

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

- Services, supplies, and courses of treatment that are customary for the treatment or diagnosis of an Illness or Injury, and are 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 Claim Administrator or Medical Advisor initially will determine if a service or supply is Medically Necessary. The Plan will not pay for hospitalization, medical services, or supplies that are not considered Medically Necessary. The judgment of the Claim Administrator or the Medical Advisor about Medical Necessity relates only to benefit coverage under this Plan. Keep in mind that the determination of Medical Necessity may be different from the judgment made by the Covered Person and doctor. The care actually received will depend on the decisions reached by the Covered Person and the doctor; the decision to seek and obtain medical treatment or any other health care service is solely that of the Covered Person. The presence or absence of benefit coverage should not be the only criteria used to determine what medical treatment is received. The Covered Person should not use the availability of benefits coverage to determine what Medical Care or treatment the Covered Person receives.
- Hospitalization, for purposes of benefit coverage only, will be determined to be Medically Necessary when the medical services received require a Hospital Inpatient setting. If services could be provided appropriately 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 patient’s condition, an Inpatient Hospital stay will not be considered Medically Necessary.

Examples of services and supplies that are not Medically Necessary include, but are not limited to:

- Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in another setting, such as a Physician’s office or Hospital Outpatient department;
- Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and diagnostic tests) that could have been provided safely and adequately in some other setting, such as a Physician’s office or Hospital Outpatient department;

- Continued Inpatient Hospital care when the patient’s medical symptoms and condition no longer require a continued Hospital stay;
- Hospitalization or admission to any Inpatient setting including acute Hospital, Skilled Nursing Facility, subacute or acute rehab facility, long-term acute care Hospital (LTACH), or other facility for the primary purposes of providing Custodial Care service, 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 merely because care in the home is not available or is not suitable;
- Private Duty Nursing;
- Care that is considered Experimental, Investigational, or in conflict with accepted medical standards;
- Any care determined to be custodial;
- Treatment of Mental Illness or Substance Abuse that is not part of a documented, prescribed, complete treatment plan established by the Physician or is not an established plan appropriate for the diagnosed condition; and
- Treatment performed by a Physician who is not licensed at a level appropriate to the type of care required.

Notwithstanding the preceding, for purposes of the Medicare Supplement Retiree Healthcare Plan, whether services and supplies are “Medically Necessary” will be determined by Medicare in accordance with its rules for services subject to Parts A and B of Medicare, except as described starting on page 68.

Medicare

The program established by Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

Medicare Approved

A Provider that has been certified or approved by the Department of Health and Human Services for participation in the Medicare program.

Medicare Secondary Payer (MSP)

Those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y(b), and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, that regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their Spouses and, in some cases, dependent children.

Medicare Supplement Retiree Healthcare Plan

The Plan offered to Covered Persons who have Medicare as their primary coverage

Mental Illness

Those illnesses classified as disorders in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Non-Medicare Eligible Retiree Healthcare Plan

The Plan offered to Covered Persons who do not have Medicare as their primary coverage.

Non-Participating Hospital

See definition of *Hospital* on page 10.

Non-Participating Provider

See definition of *Provider* on page 16.

Occupational Therapist

A duly licensed occupational therapist.

Occupational Therapy

Constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop or acquire a physical function.

Outpatient

Treatment received while not an Inpatient. Services considered Outpatient include, but are not limited to, services in an emergency room regardless of whether the Covered Person is subsequently registered as an Inpatient in a health care facility.

Participating Hospital

See definition of *Hospital* on page 10.

Participating Provider

See definition of *Provider* on page 16.

Pension Fund

See definition of *Fund or Pension Fund* on page 10.

Pharmacy

Any licensed establishment in which the profession of pharmacy is practiced.

Pharmacy Benefit Manager

An entity as indicated in the Important Contact Information Section, separate from the City, the Claim Administrator or the Funds, that manages the Prescription Drug program and that establishes the arrangements and discounts for prescription benefits with pharmaceutical companies.

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.

Physical Therapist

A duly licensed physical therapist.

Physical Therapy

The treatment of a disease, injury, or condition by physical means by a Physician or a registered professional Physical Therapist under the supervision of a Physician and that is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop or acquire a physical function.

Physician

A legally qualified practitioner of the healing arts acting within the scope of his or her license and as defined under the laws of the state where the treatment is rendered.

Physician Assistant

A duly licensed physician assistant performing under the direct supervision of a Physician, Dentist, or Podiatrist and billing under such Provider.

Plan

One or both of the two group healthcare plans offered by the City of Chicago to Retirees and their eligible dependents, Surviving Spouse Annuitants, and Child Annuitants: the Medicare Supplement Retiree Healthcare Plan and/or the Non-Medicare Eligible Retiree Healthcare Plan.

Plan Administrator

The entity authorized to act on behalf of and administer the Plans, which is the City of Chicago.

Plan Sponsor

The entity that defines the group for coverage purposes and that contracts with the Claim Administrator, the Medical Service Advisor, the Pharmacy Benefit Manager, networks, and others on an as-needed basis for the provision of services under the Plan. For these Plans, the Plan Sponsor is the City of Chicago.

Preferred Provider Organization (PPO)

A program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

Prescription Drugs

Drugs or medicines that require a doctor's signature to dispense and are approved by the United States Food and Drug Administration for use in treating the sickness or injury for which they are prescribed.

Private Duty Nursing

Hourly nursing care provided in a patient's home on either an intermittent or shift basis 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, routine supportive care, or to provide services for the convenience of the patient and/or his or her family.

Professional Provider

See definition of *Provider* on page 16.

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.

- **Participating Provider:** A Provider that has a written agreement with the Claim Administrator or a PPO network plan to provide services to Covered Persons in the PPO program or an Administrator facility that has been designated by the Claim Administrator as a Participating Provider.

Participating Providers are Hospitals, Ambulatory Surgical Facilities, licensed Outpatient clinics, and the following individual professionals:

- Physicians.
- Podiatrists.
- Psychologists.
- Certified Nurse-Midwives.
- Chiropractors.
- Clinical Social Workers.
- Clinical Professional Counselors.

- Clinical Laboratories.
- Certified Registered Nurse Anesthetists.
- Physical Therapists.
- Occupational Therapists.
- Speech Therapists.

Who have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill patients in this Plan for Covered Services amounts in excess of the Maximum Allowance. Therefore, the Covered Person is responsible only for the difference between the Claim Administrator's benefit payment and the Maximum Allowance for the particular Covered Service – that is, the Deductible and Co-Payment amounts.

- **Non-Participating Provider:** A Provider that does not have a written agreement with the Claim Administrator or a PPO Network plan to provide services to Covered Persons in the PPO program or a facility and thus has not been designated by the Claim Administrator as a Participating Provider.

Non-Participating Providers include Hospitals, Ambulatory Surgical Facilities, Outpatient clinics, or the following professionals:

- Physicians,
- Podiatrists,
- Psychologists,
- Dentists,
- Certified Nurse-Midwives,
- Chiropractors,
- Clinical Social Workers,
- Clinical Professional Counselors,
- Clinical Laboratories,
- Certified Registered Nurse Anesthetists,
- Physical Therapists,
- Occupational Therapists,

- Speech Therapists, and
- Other Professional Providers,

Who have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, each Covered Person is responsible to these Non-Participating Providers for the difference between the Claim Administrator's benefit payment and such Provider's charge.

- **Professional Provider:** A Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Clinical Social Worker, or any Provider designated by the Claim Administrator or a PPO network plan.
- **Participating Prescription Drug Provider:** A Pharmacy that has a written agreement with the Claim Administrator, Plan Sponsor, or the Pharmacy Benefits Manager to administer its prescription drug program to provide services at the time the services are received.

Psychologist

A Registered 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 services 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.
- **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.

Renal Dialysis Treatment

One unit of service including the equipment, supplies and administrative service that are customarily considered as necessary to perform the dialysis process.

Retiree

A person receiving an age and service annuity from one of the City's four Pension Funds based solely upon that person's City of Chicago employment.

Retiree Benefit Booklet

This document describing the benefits provided under the Plan.

Schedule of Maximum Allowances

The fee schedule, as revised from time to time, setting forth the maximum rate that a particular Professional Provider has agreed to accept as payment in full for services provided pursuant to his or her contract with the Claim Administrator.

Skilled Nursing Facility

An institution or a distinct part of an institution that is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services.

Skilled Nursing Service

Those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) that require the technical skills and professional training of an R.N. or L.P.N. and that cannot reasonably be taught to a person who does not have specialized skill and professional training. Skilled Nursing Service does not include Custodial Care service or Private Duty Nursing.

Speech Therapy

The treatment for the correction of a speech impairment resulting from disease, and trauma that is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training or services designed and adapted to develop or acquire a physical function.

Speech Therapist

A duly licensed speech therapist.

Spouse

The person who is legally married to the Retiree under the laws of any state or foreign nation as of the date the Retiree leaves City service, and who is not divorced from the Retiree during the period of coverage for which required contributions have been made.

Substance Abuse

The uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency that develops with continued use of such addictive substances requiring Medical Care as determined by a Physician or Psychologist.

Sudden and Serious Illness

Any acute and severe condition or symptom that constitutes an extremely hazardous medical condition that could jeopardize the patient's life or cause serious harm to the patient's health if not treated immediately.

Surgery

The performance of any medically recognized, non-Investigational surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Medical Advisor or the Claim Administrator.

Surviving Spouse Annuitant

A person receiving an annuity from one of the City's four Pension Funds who is entitled to that annuity based solely upon that person's deceased Spouse's City of Chicago employment.

Temporomandibular Joint Dysfunction and Related Disorders

Jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jawbone and skull and the complex of muscles, nerves and other tissues relating to that joint.

Unique Identification Number

The unique number assigned to the Retiree, Surviving Spouse Annuitant, or Child Annuitant for purposes of claim administration. This number appears on your Plan identification card.

Years of City Service

Years of actual employment with the City, for which pension service credit under one of the Funds also is recognized, without regard to reciprocal service with another agency or unit of government. The service need not be continuous.

Eligibility, Enrollment, and Termination of Coverage

This Section Applies to Both Plans

Who Can Enroll:

Retiree, Surviving Spouse Annuitant, Child Annuitant

The following persons are eligible to enroll in the Plans:

A Retiree (as defined on page 18);

A Surviving Spouse Annuitant (as defined on page 20) provided that the Spouse was covered under one of the health plans offered to active employees as of the Retiree's last day of active City employment; and

A Child Annuitant (as defined on page 4) provided that the child was covered under one of the health plans offered to active employees as of the Retiree's last day of active City employment or was in utero during the time of employment.

Notwithstanding the preceding, if the Retiree retired on or after August 23, 1989, eligibility for such Retiree and his or her Dependents (as well as any related Surviving Spouse Annuitant or Child Annuitant) will end as of midnight on December 31, 2016.

Dependents

Dependents may be enrolled if they were covered as the employee's Spouse, Domestic Partner, Civil Union Spouse, or dependent child under a City of Chicago active employee health benefit plan on the retiree's Last Day of Active Employment with the City, and under the following conditions:

- The Spouse was married to the former employee as of the date of retirement and the couple has not since divorced;
- The Domestic Partner has satisfied the requirements of City of Chicago Municipal Code Section 2-252-072, and was covered as an eligible Domestic Partner dependent by the City of Chicago on the last day of the Retiree's active work before retirement (For more information on coverage of Domestic Partners, see page 23);
- The Civil Union Spouse was the Civil Union Spouse of the former employee as of the date of retirement and the couple has not since terminated the civil union;
- Unmarried children of the former employee under age 25, if the employee retired before January 1, 1986, and the former employee has been continuously covered by the Plan since the employee retired;

If the former employee retired on or after January 1, 1986, then the following dependents may be covered:

- Unmarried children under age 19; and
- Unmarried children who are at least 19 years of age and less than 22 years of age, if they are enrolled as full-time undergraduate students in a community college, college, or university accredited by the Higher Learning Commission's North Central Regional Association or its affiliates, provided that all other eligibility requirements are met; and
- Mentally or physically disabled children of any age who depend upon the retiree for support, provided all other eligibility requirements are met and that proof of mental or physical incapacity and support are provided annually and the children have been continuously covered by the Plan since the employee retired.

“Children” means individuals with respect to whom the former employee provides over one-half of the individual’s financial support who are:

- Natural children;
- Stepchildren;
- Children placed in the Retiree’s home for adoption;
- Legally adopted children; and
- Children for whom the retiree is a legal guardian pursuant to an order of a court or administrative tribunal with appropriate jurisdiction and who have the same principal place of abode as the former employee and are members of the employee’s household.

If a divorce decree or other valid judgment assigns responsibility for Medical Care of a child to another person, that child will not be eligible for coverage under this Plan.

There may be tax consequences to the receipt of benefits with respect to dependents; Retirees and their dependents should consult a tax adviser to understand these consequences.

Dependents not enrolled in the active employee health benefit plan offered by the City as of the date of the employee’s retirement, or who become dependents after the retirement date, will not be eligible for coverage.

Exceptions

Eligible dependents of retired sworn members of the Chicago Police Department or retired uniformed members of the Chicago Fire Department who have been enrolled during the post-employment period covered by a collective bargaining agreement provision related to coverage for individuals between age 55 and 65 or between age 60 and age 65 (or the age of Medicare eligibility), may be enrolled as dependents when the retiree enrolls, within 30 days, in one of the Plans following expiration of the

period of coverage under the collective bargaining agreement, provided that the dependents meet all eligibility requirements except for:

- Dependents who are eligible for their own retiree coverage from the City of Chicago, and
- Dependents who are otherwise eligible for coverage as an employee of the City of Chicago.

A Retiree retired and enrolled in Retiree health care coverage before January 1, 1986, may enroll a dependent with proof of good health on a form acceptable to the Benefits Service Center, provided all other eligibility guidelines are met.

Domestic Partners and Civil Union Spouses

Retirees may enroll as dependents those Domestic Partners and Civil Union Spouses who were covered as eligible Domestic Partners or Civil Union Spouses by the City of Chicago on the last day of the Retiree's active work before retirement. Other indications of relationship status, such as common law relationships, do not suffice to create any right to benefits.

However, continuing benefits that might otherwise apply to surviving Spouses, such as PHSA benefits, or Surviving Spouse Annuitant health benefits, do not apply to Domestic Partners or Civil Union Spouses (unless the Domestic Partner or Civil Union Spouse is receiving an annuity from one of the City's four Pension Funds). City sponsored health benefits for enrolled Domestic Partners and Civil Union Spouses terminate upon the death of the enrolling City retiree.

The former City employee who enrolls a Domestic Partner or Civil Union Spouse as a dependent is responsible for notifying the City Benefits Manager of any change in circumstances, including death or termination of the relationship that would disqualify the Domestic Partner or Civil Union Spouse from further benefits. Failure to provide this required notice may lead to suspension or termination of the former employee's health benefits. Further, the Retiree must reimburse the City for any claims paid in error on behalf of the ineligible Domestic Partner or Civil Union Spouse.

In addition, the City Benefits Manager is authorized to terminate health benefits for an enrolled Domestic Partner or Civil Union Spouse dependent of a Retiree if it comes to the attention of the City Benefits Manager that the dependent no longer is a Domestic Partner or Civil Union Spouse.

The decisions of the City Benefits Manager on termination of Domestic Partner or Civil Union Spouse eligibility may be reviewed only by the City Benefits Committee.

There may be tax consequences to the receipt of Domestic Partner or Civil Union Spouse benefits; Retirees and their Domestic Partners or Civil Union Spouses should consult a tax adviser to understand these consequences.

Proof of Dependency

To enroll a dependent in one of the Plans, the Retiree may be required to provide proof of dependent status such as but not limited to the following:

- Marriage certificate, Civil Union certificate, or birth certificate for each child to be covered;
- Divorce decree(s) if the retiree and/or Spouse are not the two natural parents shown on the child's birth certificate;
- Adoption papers for legally adopted children;
- An order regarding legal guardianship;
- Court orders showing that the Retiree is ordered to provide medical coverage for a child (Note: Children may not be added unless eligible under active employee plan prior to retirement)
- Proof of permanent and significant mental or physical incapacity and support on a form provided each year by the Benefits Management Division if incapacity is the basis for continued eligibility; and
- A statement of full-time enrollment for a dependent whose eligibility continues because the child is a full-time student in a community college, college, or university accredited by the Higher Learning Commission's North Central Regional Association or its affiliates.

Additional documents may also be required.

If any such documents are required, 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 Management Division along with the documents.

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

Coverage Under More than One City Plan

If a City retiree is eligible for coverage under one of the Plans, and a Spouse is also covered by a plan offered by the City, their dependent children can be covered under either plan, but not both. If any dependent is a City employee (eligible for health care coverage), he or she cannot be covered as a dependent under these Plans.

If both members of the couple are eligible Retirees, they cannot cover each other. Each must enroll separately in the appropriate Plan. However, if one of the Retirees is not eligible for a City subsidy toward the cost of Plan coverage, that Retiree may be covered as a Spouse, provided all eligibility requirements are met. Likewise, if one of the Retirees is no longer eligible for Plan coverage because of Plan benefits ending for such person effective as of December 31, 2016, such Retiree also then may be covered as a spouse, provided all eligibility requirements are met and provided the couple was married as of the termination of employment of the first member of the couple to terminate City employment.

Retirees, Surviving Spouse Annuitants, or Child Annuitants who are married to active City employees may be covered as dependent Spouses on one of the active employee plans. However, an active City employee who is also a Spouse of a City Retiree may not enroll in one of these Retiree Plans as a dependent.

For retirees who receive health benefits in another health plan sponsored by the City without monthly charge pursuant to a collective bargaining agreement, Spouses who are themselves Retirees may be enrolled as a dependent of the retiree until the retiree reaches age 65. However, if such Spouse is eligible for free Medicare Part A coverage, such Spouse also should enroll in Medicare Part B at the time of his or her initial eligibility for Medicare as Medicare is the primary payer for such Spouse.

Enrolling in the Plan

Retirees, Surviving Spouse Annuitants, and Child Annuitants must submit a properly completed health benefit enrollment form to the Benefits Service Center. In addition, the Retiree must have applied for and been approved to receive an age and service annuity from a City Pension Fund, and must meet all other eligibility requirements for the particular Plan before coverage will begin. No Retiree, Spouse, or dependent child may be enrolled in one of the Plans until the eligible Retiree has been approved to receive an annuity.

When Coverage Begins

Coverage begins on the first day of the month for which receipt of an annuity has been approved if a properly completed enrollment form is presented to the Benefits Service Center within 30 days of the Annuity Start Date and all other eligibility requirements are met. This applies regardless of whether the Annuity Start Date occurs at the same time as termination of employment or at a later date so long as it occurs on or before December 31, 2016. Failure to provide the required documentation in a timely manner will result in a later start date for coverage.

Example:

If a Retiree applies for an annuity in June and the Pension Fund approves the annuity as of July 1, then the Retiree has 30 days to apply for coverage from July 1. However, the Retiree should apply for health benefit coverage as soon as possible to avoid any delays or Claim Payment problems related to later enrollment.

Caution: In the example provided above, if the Retiree did not apply for an Annuity until October 1, and the annuity was approved retroactive to July 1, the Retiree would not be eligible for coverage until the first day of the month on or after the date of the application for the Annuity provided that a completed enrollment form is received within 30 days. In this case, the Retiree would not be retroactively enrolled to coincide with the Annuity Start Date and may experience a gap in coverage between the end date of coverage as an active employee and the start date of coverage as a Retiree.

For those who are confined to a Hospital on the effective date of coverage, coverage will not begin until the day after they are discharged from the Hospital.

When Dependent Coverage Begins

Coverage for enrolled dependents begins at the same time as the Retiree's coverage, provided all eligibility requirements are met. If any enrolled dependent is confined to a Hospital at the time of enrollment, coverage will not begin until the day after the dependent is discharged from the Hospital.

Delayed Enrollment

Failing to Enroll at Time of Annuity Start Date

If a former employee does not elect health benefit coverage by completing and submitting an enrollment form within 30 days of the Annuity Start Date, but later seeks coverage, then that Retiree, and any eligible dependents, may only enroll within 30 days of the Retiree reaching age 65 or upon presenting, for every enrollee, proof of good health that is acceptable to the Plan Administrator provided all other eligibility requirements are met.

Exception No. 1: City Retiree as Spouse of City Employee

If a Retiree is covered as a dependent Spouse by an active City employee as of the Annuity Start Date, then the Retiree may enroll in one of the Plans whenever the Retiree's eligibility under the active plan ceases (unless such eligibility ceases due to the Retiree's fraud or misconduct) without providing proof of good health if application for enrollment for coverage under a Plan is made within 30 days of termination of coverage under the active employee plan sponsored by the City.

Example:

John was married to Susan and both were active City employees. John retires first, and is carried as a dependent under Susan's active City coverage. If John loses City coverage due to changes in Susan's employment or a change in his marital status or due to Susan dropping his coverage during the open enrollment period, John may enroll in one of the Plans without meeting the requirements otherwise applied for delayed enrollment. John must apply for coverage within 30 days of the loss of active plan coverage. If John fails to apply within the required time frame, he must provide proof of good health that is acceptable to the Plan Administrator.

Exception No. 2: Dependents of Sworn Police or Uniformed Fire under Collective Bargaining Agreement

Police and Fire Retirees who retire, but who receive health benefits from the City under another group health plan pursuant to their collective bargaining agreements, will also be allowed to continue coverage for their enrolled dependents, without providing proof of good health, if the retiree enrolls in one of the Plans within 30 days of attaining age 65.

Separate Enrollment Period for Surviving Spouses and Surviving Children

If a Retiree commences coverage following termination of City employment and later dies, a surviving Spouse or surviving child may continue coverage if the Spouse or child is eligible for a surviving Spouse annuity or surviving child annuity, respectively, provided that the Spouse or child was covered under the group health plan offered by the City to active employees as of the last date of

the former employee's active employment and provided that the Spouse or child submits a completed enrollment form within 30 days of becoming a Surviving Spouse Annuitant or Child Annuitant, respectively. A Surviving Spouse Annuitant or Child Annuitant who does not enroll within the 30-day period, may enroll at a later date provided that such individual presents a provides proof of good health that is acceptable to the Plan Administrator. All other eligibility requirements must be met.

Medicare Eligibility and Enrollment

Duty to Give Notice

Covered Persons aged 65 and over, who are enrolled in the Non-Medicare Eligible Retiree Healthcare Plan, are required, as a condition of coverage, to provide proof to the Benefits Office from the Social Security Administration confirming that they are **not** eligible for Medicare. This must be submitted to the Benefits Service Center on an annual basis.

Further, those Retirees, Surviving Spouse Annuitants, and Child Annuitants or Spouses of Retirees under age 65 who have Medicare coverage due to a disability must also notify the Benefits Service Center of their Medicare coverage. If someone has Medicare coverage under age 65, the Plan will pay as secondary coverage unless such secondary payment is prohibited by the Medicare Secondary Payer regulations. If any claim is paid by the Plan as the primary payer when the Plan is the secondary payer, then the Retiree must reimburse the Plan for any amount paid in excess of the Plan's obligation as the secondary payer to Medicare.

Benefits under the City's Plans may also be terminated for those who fail to provide to the Benefits Office written confirmation from the Social Security Administration regarding their Medicare status when requested, regardless of whether they have actually enrolled in Medicare.

Failure to Enroll in Medicare when Eligible

At age 65, upon becoming disabled, or after the first 30 months of Medicare eligibility based on end stage renal disease, Covered Persons will be enrolled in the Medicare Supplement Retiree Healthcare Plan for Medicare eligible Retirees, unless they have provided the Benefits Service Center with a letter from the Social Security Administration confirming that they are not eligible for Medicare. The Benefits Service Center will notify the Pension Fund to change the contribution amount to reflect the contribution required for the Medicare Supplement Retiree Healthcare Plan as of the first day of the month in which the Retiree, Surviving Spouse Annuitant, Spouse, or Disabled Dependent Child attains age 65 or otherwise becomes eligible for Medicare as primary coverage. The Benefits Service Center will also report to the Plan's Claim Administrator that all claims are to be paid in the secondary position to Medicare as of the same effective date. If a Retiree fails to document that he or she is not eligible for Medicare on a timely basis and later does so, no claims will be adjusted until the Retiree pays the required amount of contributions. In addition, no claims will be retroactively adjusted if the date of the medical service was more than two years from the date on which the Retiree reported the correct Medicare status to the Benefits Service Center.

If a Covered Person becomes eligible for free Medicare Part A, but fails to enroll in Part B or waives enrollment in Part B, then the Plan will pay benefits as though the Covered Person is enrolled in both Part A and Part B of Medicare without regard to actual enrollment. Special rules apply to Part B enrollment. For further information, see page 69.

Persons who may not be eligible for Medicare on the basis of their own work record may become Medicare-eligible based upon the work record of a Spouse or a former Spouse. In the event that either of the Plans pays eligible claims as primary benefits when the Covered Person has not enrolled in Medicare despite being eligible, or when the Covered Person has failed to inform the City of his or her enrollment in or eligibility for Medicare, then the Plan Administrator will seek repayment from Medicare and/or the Covered Person for claims processed incorrectly (unless prohibited by the Medicare rules).

Plan Costs

The Plan is funded by a combination of City funds and Retiree contributions. The amount of the Retiree contributions in effect from July 1, 2013, through December 31, 2013, and as of January 1, 2014, has been communicated to you. Information about any future changes in Retiree contribution rates will be provided to you prior to effective date of the change. The contribution rates may be changed by the City in its sole discretion at any time and for any reason

Those former City employees who retire and/or commence receipt of an annuity on or after July 1, 2005, and whose retirement annuity is based upon less than 10 Years of City Service will only be eligible to participate in one of the Plans at their own full expense. However, such persons may be eligible for a subsidy from the Pension Fund. Such persons must pay the full cost of coverage and may not apply for any Co-Payment or reductions in monthly contribution rates under the Means Test.

The Retiree, Surviving Spouse Annuitant, or Child Annuitant's monthly cost for the coverage elected will be deducted from the Retiree's monthly annuity. If, for some reason, the monthly rate exceeds the monthly annuity at any point, then the Retiree is responsible for remitting payment for coverage to the Benefits Service Center, or to the Pension Fund, if so instructed, before the 15th day of the month preceding the month for which coverage is being paid. Failure to pay required contributions will result in termination of coverage. Coverage cannot be reinstated following termination for non-payment of contributions.

Refund Requests for Premium Overpayment

Requests for refunds due to changes in enrollment or eligibility will be processed according to established guidelines. The City of Chicago has these guidelines for requesting premium refunds. You need to notify the Pension Fund as directed below should one of the following events occur:

Event	When to Notify the Pension Fund Office
- Medicare Eligibility	The annuitant must notify the Fund within 60 days of the date of Medicare eligibility.
- Death of a spouse or dependent - Divorce - Dependent reaches the Plan's age limitation	The annuitant must notify the Fund within 90 days of the date of the event.
- Coverage cancellation for any annuitant and/or family member	The annuitant must submit the request in writing to the Fund 30 days before the cancellation date.

Event	When to Notify the Pension Fund Office
- Surviving spouse remarriage or death	Coverage ends at the time of remarriage or death. The annuitant must notify the Fund within 30 days of the date of the event.

Note: If notifications are made outside of these time limits, refunds are calculated from the date of notification, not from the date of the event. In addition, refunds will not be issued if services have been provided and related claims paid after the date of the event (i.e., Medicare eligibility, divorce, coverage cancellation). The annuitant will be billed for claims premiums paid for an ineligible dependent.

Lifetime Maximum Amount Accumulates All City Retiree Plan Payments

The Lifetime Maximum Benefit that is available under the Plan is \$1,500,000 per person. This amount includes all expenses incurred (including prescription drug benefits) on or after January 1, 2011, under any self-funded medical plan offered by the City to its Retirees and eligible dependents, Surviving Spouse Annuitants, and Child Annuitants, including under this Plan or the predecessor Annuitant Settlement Healthcare Plans. Coverage will be terminated for each person for whom the Lifetime Maximum Benefit amount has been paid.

Termination of Coverage

Benefits will no longer be available, and coverage will terminate, for individuals under the following circumstances:

- If the Plan is discontinued;
- When the Covered Person no longer meets the eligibility requirements of the Plans;
- When the Retiree, Surviving Spouse Annuitant, or Child Annuitant is no longer an eligible Retiree of one of the City’s four Pension Funds based upon City employment;
- If it is determined that the Covered Person has knowingly presented bills for services that have not been received or for a dependent or other person who is not eligible or otherwise wrongfully attempts to assign or transfer coverage or to obtain benefits through fraud or misrepresentation;
- If the required monthly contributions have not been paid as required;
- If the Retiree, Surviving Spouse Annuitant, or Child Annuitant elects to drop coverage;
- With respect to covered Spouses and dependents, if the Retiree’s coverage ceases for any reason other than due to reaching the lifetime maximum;
- When the Covered Person reaches the Lifetime Maximum amount (other family members may remain covered under these circumstances); or
- When the Covered Person dies.

Additionally, with respect to Retirees who retired on or after August 23, 1989, coverage will terminate effective as of midnight, December 31, 2016.

It is your responsibility to notify the Plan of a change in circumstances such that you, your Spouse, or a dependent child no longer are eligible for coverage under the Plans (for example, due to divorce, marriage, attainment of a certain age, no longer being a full-time student, or ceasing to be financially dependent on the parent). Failure to do so on a timely basis could result in loss of coverage for the Retiree, Surviving Spouse Annuitant, or Child Annuitant, Spouse and dependents.

Caution: Limited Reinstatement

If you choose to drop coverage for yourself or an eligible dependent, you (or your dependent) will only be able to enroll at a later date if you (or your dependent) are able to prove that you (or your dependent) are in good health UNLESS you qualify for the exceptions stated here.

Exceptions

If you as a Retiree, Surviving Spouse Annuitant, or Child Annuitant, are eligible and elect coverage under an active employee plan sponsored by the City and then return to Retiree Plan coverage within 30 days of the loss of coverage under the active employee plan, the good health requirement does not apply.

If you are a dependent and lose coverage due to a loss of student status, enroll in PHSA continuation coverage, and then subsequently regain student status, you may re-enroll within one year of loss of coverage without proving good health, provided you are still under 22 years of age.

Continuation of Coverage Following Termination If the Retiree Dies Surviving Spouse Coverage

A surviving Spouse who is covered under this Plan at the time of a retiree's death and who becomes a Surviving Spouse Annuitant may continue coverage until the earliest of the following:

- The date of his or her remarriage;
- The date of his or her death;
- The date on which the surviving Spouse reaches the Lifetime Maximum Benefit amount;
- The last day for which required contributions are made;
- The date on which the annuity ceases; or
- The date the Plan is terminated or coverage is terminated for the category of Retirees of which the surviving Spouse is a member.

If the surviving Spouse is not eligible to receive a Surviving Spouse Annuity, then the surviving Spouse may elect coverage under the PHSA provisions provided below on page 31.

Surviving Dependent Children Coverage

If a surviving Spouse receives a Surviving Spouse Annuity, dependent children who were covered under this Plan at the time of the Retiree's death may elect to continue coverage as the dependent children of the Surviving Spouse Annuitant; or, if the dependent child receives a Child Annuity, coverage may be continued for the Child Annuitant until the earliest of the following events occur:

- The date the annuity payment ceases;
- The day on which he or she reaches age 19 (or age 22 if an eligible full-time student), or age 25 if the former City employee retired before January 1, 1986, unless he or she is disabled and can present adequate proof of same;
- The date of his or her death;
- The date of his or her marriage;
- The date on which the dependent child reaches the Lifetime Maximum Benefit amount;
- The last day for which required contributions are made; or
- The date the Plan is terminated or coverage is terminated for the class of Retirees of which the dependent child is a member.

If the surviving Spouse does not receive a Surviving Spouse Annuity and the child does not qualify for a Child Annuity, the dependent child may elect coverage under the PHSA (Public Health Service Act) provisions provided below.

Continuing Medical Coverage under PHSA

In accordance with applicable law, when coverage under either of these Plans ends, medical benefits may be continued, depending upon the circumstances, at the Covered Person's own expense for a temporary period. To be eligible, a qualifying event causing the loss of coverage must take place.

Dependents can continue coverage for up to 36 months if one of the following qualifying events takes place:

- The retiree and Spouse divorce or legally separate;
- The dependent children are no longer eligible because of marriage, reaching the limiting age, no longer meeting student status requirements, or otherwise ceasing to be eligible as a dependent;
- The Retiree dies and the surviving Spouse is not eligible for a Surviving Spouse Annuity; or
- The Retiree dies and a dependent child is not eligible to continue coverage.

The benefits provided will be the same as those provided to dependents covered under the Plan available to the Retiree. If the Plan changes, benefits provided under continuation of coverage will also change. However, if a Covered Person reaches his or her Lifetime Benefit Maximum then no benefits would be available to the Covered Person.

It is not a qualifying event if the Retiree, Surviving Spouse Annuitant, or Child Annuitant elects to stop coverage and/or stops paying required monthly contributions for himself or herself or any dependents. It is not a qualifying event if the Retiree elects to stop coverage for a dependent unless the reason for the termination of the dependent qualifies as provided above. For example, if a Retiree elects to stop covering a Spouse because the Spouse has obtained other coverage, there is no qualifying event and PHSA coverage will not be available to the Spouse.

This continuation coverage will stop before the 36-month period if one of the following events occurs:

- Failure to pay the full cost for coverage on or before the due date;
- The Covered Person obtains coverage under another group health plan, unless coverage is delayed for pre-existing conditions;
- The Covered Person becomes Medicare entitled;
- The applicable Plan is terminated and the City of Chicago ceases to offer group health coverage for which the Covered Person might be eligible; or
- The Covered Person reaches his or her Lifetime Maximum amount.

Cost of Continuation Coverage

If the eligible dependents choose to continue coverage, they will have to pay the full cost of coverage plus a 2% administrative fee permitted under applicable law. The dependents will be notified of the cost. This cost may change once a year.

How to Apply/Notification Requirements

The Retiree, Surviving Spouse Annuitant, or Child Annuitant or other Covered Person must notify the City at the address listed in the Important Contact Information Section in writing within 60 days after one of these qualifying events occurs (or the date of loss of coverage, if later) to be eligible for continuation coverage:

- The retiree and Spouse legally separate and the retiree stops the Spouse's and/or child's coverage;
- The retiree and Spouse divorce;
- A dependent child turns age 19 (or age 25 if the City employee retired before January 1, 1986);

- The dependent child turns age 22 if he or she has been enrolled as a full-time undergraduate student;
- The dependent child who is required to be a full-time student to be eligible for coverage ceases to be a full-time student;
- The dependent child ceases to receive over one-half of his or her support from the former employee; or
- The Retiree has died.

The notice must be mailed or hand-delivered; oral notice, including notice by telephone, is not acceptable. If mailed, the notice must be postmarked no later than the deadline. If hand-delivered, the notice must be received no later than the deadline. Notice that is sent via fax is acceptable, but it is YOUR responsibility to ensure that electronic notice was received by the appropriate person by the deadline. This written notice must contain the Plan name, the former employee's name, address, birth date, and social security (or other identification) number, the name and address of any impacted Spouse or dependent, a description of the event, including the date, and adequate documentation of the event (such as a death certificate or published obituary, divorce or legal separation decree, a copy of the dependent's birth certificate, or a transcript showing the dependent's last date of enrollment in an educational institution, as applicable). The notice may be provided by the former employee, the impacted Spouse or dependent, or a representative acting on behalf of either one. A form for providing this notice may be available from the Plan Administrator, but need not be used so long as all the relevant information is included in the written notice. Oral notice, including notice via telephone, is not acceptable, nor is notice sent via electronic mail.

After the City has been notified that a qualifying event has occurred, the City will notify the Covered Persons about the options to continue coverage. If the Retiree, Surviving Spouse Annuitant, or Child Annuitant or dependents fail to notify the City within the required time frame, the Plan Administrator may not continue coverage.

To continue coverage, the eligible dependent must submit his or her election in writing. To preserve his or her right to elect continuation coverage, the eligible dependent (or a representative acting on his or her behalf) must complete and return the election form provided by the City as soon as possible, but no later than 60 days after the later of (i) the date of the notice from the City, or (ii) the date coverage otherwise would end. The completed election form must be returned to the Plan Administrator at the address indicated in the *Important Contacts* portion of this document. It may be returned via hand-delivery, U.S. Mail, or some form of express mail delivery. If mailed, it must be post- marked by the date the election period ends. (While not required, we recommend that you obtain proof of mailing from the post office or other delivery service.) An election that is sent via fax is acceptable, but it is YOUR responsibility to ensure that fax is received by the appropriate person by the deadline.

If an eligible dependent 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 dependent 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.

Fraudulent Continuation of Coverage

If a Retiree fails to notify the City's Benefit Service Center of an event that would cause the coverage of a dependent to be terminated, the Retiree shall 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. The City may, at its option, pursue collection or elect to offset such amounts against the future benefits of the Retiree and any remaining covered dependents. Moreover, the City at its option may terminate the Retiree's coverage based on the Retiree's failure to notify the City of an event that would cause the coverage of a dependent to be terminated.

Fraudulent Coverage/Non-Transfer/Failure to Notify

Any kind of fraud on the Plan may result in adverse consequences to a Retiree, a surviving Spouse Annuitant, or a Child Annuitant, and any covered dependents. Examples of fraud include:

- Failure to notify the City's Benefits Service Center of an event that would cause the coverage of a Covered Person to end (such as divorce).
- Misrepresentation by the Retiree, a Surviving Spouse Annuitant, or Child Annuitant, or any covered dependent regarding the initial eligibility of himself or a dependent in the first place. The Retiree 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 Retiree, Surviving Spouse Annuitant, or Child Annuitant and any remaining covered dependents. Moreover, the City at its option may terminate the coverage of the Retiree and any remaining covered Dependents based on the failure to notify the City of an event that would cause the coverage of a Covered Person 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, if you fail to timely notify the City of a PHSA qualifying event, you or your dependent (as applicable) will not be entitled to PHSA continuation coverage.

Non-Medicare Eligible Retiree Healthcare Plan

Non-Medicare Eligible Benefit Summary as of

Detailed information on each item appears on the page number provided.

Plan Term	Participating	Non-Participating	Living Out of a Network Area	See Page(s)
Lifetime Maximum Benefit	\$1,500,000 per covered person for medical and prescription drug benefits. (Includes all amounts paid on or after January 1, 2011 under the Non-Medicare Eligible Retiree and Medicare Supplemental Retiree Plans combined)			43
2013 Deductibles	\$391 Individual \$1,173 Family	\$914 Individual \$2,742 Family	\$391 Individual \$1,173 Family	
2014 Deductibles	\$403 Individual \$1,209 Family	\$941 Individual \$2,823 Family	\$403 Individual \$1,209 Family	38
Deductible for Care Received Outside United States	\$250 per person per year			69

Plan Term	Participating	Non-Participating	Living Out of a Network Area	See Page(s)
Covered Person's Share of Covered Medical Expenses after Deductible for Other than Prescription Drugs	<p>10% for Emergency Room Services</p> <p>20% for the following*:</p> <ul style="list-style-type: none"> • MRI, PET, and CAT Scans¹ • Occupational and Speech Therapy¹ • Physical Therapy • Prosthetic Devices and Durable Medical Equipment¹ • Ambulance Transportation¹ • Skilled Nursing Facility¹ • Skilled Home Health Care¹ • Hospice Care¹ • Outpatient Mental Health and Substance Abuse Treatment¹ <p>10% for the following Participating Providers / 30% for the following Non-Participating Providers*:</p> <ul style="list-style-type: none"> • Hospital Inpatient¹ • Hospital Outpatient • Doctor (Office) Visits • Chiropractor Visits <p>Note: Routine screening exams/physicals are not covered.</p> <p>Note: Diagnostic Lab Tests performed by an independent PPO lab (i.e., Quest) paid in full by Plan (with 0% paid by Covered Person) if all requirements are met.</p> <p>*With respect to Non-Participating Providers, covered persons also will be required to pay any charges in excess of the Maximum Allowance.</p> <p>¹ These services require pre-certification through the Utilization Review Provider, pursuant to Plan guidelines</p>			39
Prescription Drug Deductible	\$100 per person for drugs purchased at a retail Pharmacy location (Does not apply to Means Test Eligible Retirees)			83

Plan Term	Participating	Non-Participating	Living Out of a Network Area	See Page(s)
<p>Covered Person's Share for Prescription Drugs (Cost per mail order prescription will increase 5% per year rounded to the nearest dollar.)</p> <p>Different provisions apply to Means Test Eligible Retirees, see page 103.</p>	<p>For up to a 30-day supply at retail or 100 unit dose (whichever is less):</p> <ul style="list-style-type: none"> • Generic Drugs.....20% • Formulary Brand Drugs.....20%* • Non-Formulary Brand Drugs.....20% plus \$15* <p>For up to a 90-day supply through Mail Order Prescription Drug Program:</p> <ul style="list-style-type: none"> • Generic Drugs.....\$24 in 2013/\$25 in 2014 • Formulary Brand Drugs.....\$62 in 2013/\$65 in 2014* • Non-Formulary Brand Drugs.....Not Available at Mail <p>* If you receive a Brand Drug when a Generic Drug alternative is available, you will pay the cost difference between the Brand and the Generic in addition to the required generic Co-Payment.</p>			<p>82</p> <p>84</p>
<p>2013 Out-of-Pocket Expense Limit (Does not include Covered Person's share of prescription drug expenses.)</p>	<p>\$2,284 Individual; \$4,568 Family</p>	<p>\$4,566 Individual; \$9,132 Family</p>	<p>\$2,284 Individual; \$4,568 Family</p>	
<p>2014 Out-of-Pocket Expense Limit (Does not include Covered Person's share of prescription drug expenses.)</p>	<p>\$2,353 Individual; \$4,706 Family</p>	<p>\$4,703 Individual; 9,406 Family</p>	<p>\$2,353 Individual; \$4,706 Family</p>	<p>39-40</p>

Medical Plan Benefits for Non-Medicare Eligible Retirees and Dependents

The Plan includes a PPO network, which is a network of Providers who have agreed to provide services under a contract with the Claim Administrator. Contracted Providers (PPO Providers) include Hospitals, skilled nursing facilities, Physicians, Physical Therapists, and many other medical

Providers. If you live in a PPO network area and you use the services of a Participating Provider, you will receive the maximum benefit available under the Plan. If you do not use a Participating Provider and you live in a PPO network area, your benefits under the Plan will be reduced and you will pay more out of pocket. If you do not live in a network area, your benefits will be provided as specified.

The choice of Provider ultimately is your decision. Moreover, the fact that a Provider is a “Participating Provider” is not a recommendation or referral, nor is it a statement as to the ability or quality of such Provider by the Plan or Claim Administrator. Likewise, the fact that a Provider is a “Non-Participating Provider” is not a statement as to the Provider’s skill or quality by the Plans or Claim Administrator. Further, neither the Plan nor the Claim Administrator will be liable for any act or omission of any Provider.

Benefit Period

The Benefit Period is a period of one year, beginning on January 1 and ending on December 31 of each year. For those enrolling for the first time, the first Benefit Period begins on the Coverage Date and ends on December 31 of the same calendar year.

Payment Provisions

Within each Benefit Period, each Covered Person must satisfy a Deductible for Covered Services. In other words, after the total dollar amount of claims for Covered Services reaches more than the Deductible amount in a Benefit Period, the Plan will pay benefits for Covered Services as indicated in this section. The Participating Provider Deductible and the out of network Deductible are separate Deductibles. Expenses applied towards the satisfaction of one Deductible will not be applied towards the satisfaction of the other Deductible. The Deductibles do not include such expenses as Co-Payments for prescriptions or any penalties that may apply due to failure to participate in the Medical Advisor Review Program.

Deductible

Participating (Network) Providers or Covered Persons Living Outside Network Area

The Deductible for Covered Services performed by a Participating Provider (a PPO Provider) and for Covered Services performed by a Non-Participating Provider for a Covered Person who lives outside a network area will be \$391 per person, or a maximum of \$1,173 for a family of three or more for calendar year 2013, and, for calendar year 2014, will be \$403 per person, or a maximum of \$1209 for a family of three or more. This Plan is first effective July 1, 2013; however, amounts accumulated towards your Deductible between January 1, 2013, and June 30, 2013, will apply to the Benefit Period running from July 1, 2013, to December 31, 2013.

After the Deductible has been met, the Plan will then pay a percentage of the Maximum Allowance for each charge. There is no carryover deductible provision. A new Deductible will be applied to each Benefit Period.

Non-Participating Providers and Covered Persons Living Within Network Area

The Deductible for Covered Services performed by a Non-Participating Provider for a Covered Person who lives in a network area will be \$914 per person or a maximum of \$2,742 for a family of three or more for calendar year 2013, and, for calendar year 2014, will be \$941 per person, or a maximum of \$2,823 for a family of three or more,. This Plan is first effective July 1, 2013; however, amounts accumulated towards your Deductible between January 1, 2013, and June 30, 2013, will apply to the Benefit Period running from July 1, 2013, to December 31, 2013.

After the Deductible has been met, the Plan will then pay a percentage, described below, of the Eligible Charge. There is no carryover deductible provision. A new Deductible will be applied to each Benefit Period.

Plan Payment Levels after Deductibles Have Been Met

For PPO services provided in a PPO network area by a Participating Provider or for services provided in an area in which there is no PPO network of Providers or in a PPO area for types of services for which there is no network, the Plan will pay 80% to 90% of the Maximum Allowance. You will pay 10%-20% as set forth earlier in the summary chart until you reach your Out-of-Pocket Expense Limit, as explained in the next section. This payment level applies also to services for Emergency Medical Care provided in a PPO network area by a Non-Participating Provider.

For PPO services provided in PPO network area by a Non-Participating Provider, the Plan will pay 70% to 80% of the Maximum Allowance. You will pay 20% to 30% until you reach your Out-of-Pocket Expense Limit.

Out-of-Pocket Expense Limit

The Out-of-Pocket Expense Limit is the amount of expenses the Covered Person must pay during the Plan year before the Plan begins to cover expenses subject to the Out-of-Pocket Expense Limit at 100%. The applicable limits are set forth in the summary chart above. Note: Any amounts accrued towards the Out-Of-Pocket Expense Limit under the prior plan for the period from January 1, 2013, through June 30, 2013, shall be applied towards the Out-Of-Pocket Expense Limit for July 1, 2013, through December 31, 2013. The Out-of-Pocket Expense Limit includes any Coinsurance amounts paid as the Covered Person's share of Eligible Charges but it does not include the annual Deductible. For a complete list of items not included in the Out-of-Pocket Expense Limit, see information beginning on page 42. There are separate Out-of- Pocket Expense Limits applicable to Covered Services received from Participating Providers and Non- Participating Providers. Amounts accumulated towards the PPO and Non-PPO Out-of-Pocket Expense Limits may not contribute to both Out-of-Pocket Expense Limits; each is separate. The PPO Out-of- Pocket Expense Limit includes both PPO and out of area benefit amounts. The non-PPO Out-of-Pocket Expense Limit includes only those expenses incurred for Non-Participating Providers in an area in which there are Participating Providers available.

If only the Retiree, Surviving Spouse Annuitant, or Child Annuitant is covered by the Plan, the individual Out-of-Pocket Expense Limits described in the following section apply. If a Retiree is covering a Spouse or dependent children, then two individuals in the family must meet the Out-of-Pocket Expense Limits described below.

Example:

If John is covering Mary, his Spouse, and Robert, his son, then two of the three people must meet the individual Out-of-Pocket Expense Limit before the family (John, Mary, and Robert) meets the family Out-of-Pocket Expense Limit.

Participating (PPO) Provider Services and Covered Persons Living Within Network Area

If, during the Benefit Period, a Covered Person's out-of-pocket expenses for services provided by Participating Providers or for services provided outside of a network area equal the Out-of-Pocket Expense Limit, then any additional eligible Claims for services by Participating Providers (except for those Covered Services specifically excluded below) during that Benefit Period will be paid in full up to the Eligible Charge or Maximum Allowance.

Once the total amount of PPO out-of-pocket expense reaches the limit in a calendar year for an individual, the Plan will pay 100% of covered expenses up to the Eligible Charge or Maximum Allowance for the balance of that calendar year for PPO services. When two members of the family have reached the individual Out-of-Pocket Expense Limit in a calendar year, the Plan will pay 100% of covered expenses for all covered family members up to the Eligible Charge or Maximum Allowance for the balance of that calendar year.

This PPO Participating Provider Out-of-Pocket Expense Limit may be reached by:

The payments for which each Covered Person is responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Non-Participating Provider other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when the condition is life threatening).

The following expenses for Covered Services cannot be applied to the Out-of-Pocket Expense Limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when the Out-of-Pocket Expense Limit is reached:

- Charges that exceed the Eligible Charge or Maximum Allowance;
- The Coinsurance resulting from Covered Services rendered by a Non-Participating Provider;
- Retail or Mail Prescription Drug Co-Payment amounts;
- Charges for Covered Services that have a separate dollar maximum specifically mentioned in this Retiree Benefit Booklet;
- Co-Payments, penalties, or expenses resulting from noncompliance with the provisions of the Medical Advisor Review Program;
- Charges for services that have been determined to be not Medically Necessary;
- Charges for services that are not Covered Services under the Plan; or

- Charges that are counted towards satisfying the Deductible.

Non-Participating Providers and Covered Persons Living Within Network Area

If, during the Benefit Period, the Covered Person's out-of-pocket expenses (the amount of the Eligible Charge that remains unpaid after the Deductible has been met and benefits have been provided) equal the Out-of-Pocket Expense Limit, any additional eligible Claims by a Covered Person who lives within a PPO network area for services provided by Non-Participating Providers (except for those Covered Services specifically excluded below) during that Benefit Period will be paid in full up to the Eligible Charge or Maximum Allowance.

Once the total amount of Non-PPO out-of-pocket expense reaches the limit in a calendar year for an individual, the Plan will pay 100% of covered non-PPO expenses up to the Eligible Charge or Maximum Allowance for the balance of that calendar year. When two members of the family have reached the individual Out-of-Pocket Expense Limit in a calendar year, the Plan will pay 100% of covered expenses up to the Eligible Charge or Maximum Allowance for the balance of that calendar year.

This Out-of-Pocket Expense Limit for Non-Participating Providers within a PPO network area may be reached by:

The payments for Covered Services rendered by a Non-Participating Provider for which the Covered Person is responsible after benefits have been provided.

It does not include:

- Charges that exceed the Eligible Charge or Maximum Allowance;
- The Coinsurance resulting from Covered Services rendered by a Participating Provider;
- Retail or Mail Order Prescription Drug Co-Payment amounts;
- Charges for Covered Services that have a separate dollar maximum specifically mentioned in this Retiree Benefit Booklet;
- Co-Payments, penalties or expenses resulting from noncompliance with the provisions of the Medical Advisor Review Program and/or the Claim Administrator's Mental Health Unit;
- Charges for services that have been determined to be not Medically Necessary;
- Charges for services that are not covered by the Plan; or
- Charges that are counted towards satisfying the Deductible.

The above discussion applies also to claims for services rendered by a Non-Participating Provider to a Covered Person who lives within a network area but has traveled outside of the area.

Services for Covered Persons Living Outside Network Area

If, during the Benefit Period, a Covered Person lives outside of an area covered by a Participating Provider network and has out-of-pocket expenses (the amount remaining unpaid after the Deductible has been met and benefits have been provided) that equal the Out-of-Pocket Expense Limit, any additional eligible Claims for services from Providers (except for those Covered Services specifically excluded below) during that Benefit Period will be paid in full up to the amount of the Eligible Charge or the Maximum Allowance. If you live more than 50 miles away from a network Hospital, you are considered to be living outside of an area covered by a Participating Provider.

Once the total amount of out-of-pocket expense reaches the limit in a calendar year for an individual, the Plan will pay 100% of covered expenses up to the Eligible Charge or Maximum Allowance for the balance of that calendar year. When two members of the family have reached the individual Out-of-Pocket Expense Limit in a calendar year, the Plan will pay 100% of covered expenses up to the Eligible Charge or Maximum Allowance for the balance of that calendar year.

This Out-of-Pocket Expense Limit for out of area Non-Participating Providers may be reached by:

The amount of the Eligible Charge not paid by the Plan for Covered Services rendered by a Non-Participating Provider outside of a network area for which the Covered Person is responsible after benefits have been provided.

It does not include:

- Charges that exceed the Eligible Charge or Maximum Allowance;
- The Coinsurance resulting from Covered Services from a Participating Provider in a PPO network area;
- The Coinsurance resulting from Covered Services from a Non-Participating Provider in a PPO network area;
- The Coinsurance resulting from Hospital services rendered by a Non-Participating Provider facility for Covered Services;
- The Coinsurance resulting from Hospital services rendered by a PPO Participating Provider facility for Covered Services;
- Retail or Mail Order Prescription Drug Co-Payment amounts;
- Charges for Covered Services that have a separate dollar maximum specifically mentioned in this Retiree Benefit Booklet;
- Co-Payments, penalties or expenses resulting from noncompliance with the provisions of the Medical Advisor Review Program;
- Charges for services that have been determined to be not Medically Necessary;

- Charges for services that are not covered by the Plan; or
- Charges that are counted towards satisfying the Deductible.

Lifetime Maximum

The total maximum amount of benefits for each Covered Person is \$1,500,000. This is an individual maximum. There is no family maximum. This amount includes all amounts paid on or after January 1, 2011, including benefits paid for Prescription Drugs, under the Non-Medicare Eligible Retiree and Medicare Supplemental Retiree Plans, combined.

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 the Important Contact Information Section.

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 Transportation (or other) or ambulance transportation from one Hospital to another	Before being transported	You pay for transportation
Will be admitted to the Hospital or Skilled Nursing Facility for a non-emergency inpatient stay	At least 24 hours before you are admitted	You pay \$1,000 of covered expenses and all expenses determined to be not medically necessary
Will be admitted to the Hospital or Skilled Nursing Facility for an emergency Inpatient stay	Within 2 business days of admission	You pay \$1,000 of covered expenses and all expenses determined to be not medically necessary
Receive Outpatient mental health or substance abuse treatment	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*
Need a Home Care Program	Before care begins	You pay all expenses
Need a Hospice Care Program	Before care begins	You pay all expenses
Require Skilled Nursing Service	Before care begins	You pay all expenses
Receive Outpatient Occupational Therapy or Speech Therapy	Before care begins	You pay all expenses
Require an organ transplant	Before care begins	You pay all expenses
Require bariatric surgery	Before care begins	You pay all expenses
Need Durable Medical Equipment	Before purchase if over \$500	You pay all expenses
Need MRI, CT or PET scan (Not applicable if administered on an Inpatient basis or while receiving Emergency Medical Care in the emergency room)	Before obtaining services	You pay all expenses if found not to be Medically Necessary
*Any extra amounts you have to pay if you don't contact the medical advisor will not count toward your deductible or out-of-pocket limit.		

The Medical Advisor Review Program is a key component of the Non-Medicare Eligible Retiree Healthcare Plan. It is designed to review certain medical care you receive to determine if it is Medically Necessary as defined by the Plan. (The Program also is utilized under limited circumstances by the Medicare Supplement Retiree Healthcare Plan; for more information, see page 64). Please review this section carefully. If you do not make required notifications on a timely basis, you will pay more for certain health care services.

To obtain maximum benefits under the Plans for certain services as described below, each Covered Person must contact the Plan's Medical Advisor, as identified in the Important Contact Information section. The Medical Advisor will review and, if appropriate, make recommendations on certification for certain types of Medical Care, including all Hospital stays, and other treatments or services as specified below.

The Medical Advisor can:

- Certify Hospital confinements for you and your dependents;
- Explain alternatives to Hospital care;
- Facilitate the early discharge of a hospitalized Retiree;
- Make recommendations about the Medical Necessity of treatments and services to the Claim 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 Certification by the Medical Advisor (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 include:
 - Durable Medical Equipment over \$500;
 - Pre-certification of DME is based on Medical Necessity and cost-effectiveness. DME is Medically Necessary if it is required for the safe and effective delivery of covered health care services. 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.
 - Outpatient Speech Therapy or Occupational Therapy;
 - Home Care Program;
 - Hospice Care Program;

- Ambulance Transportation from one Hospital to another Hospital equipped to provide special treatment;
- CAT scans, MRI scans and PET scans (unless performed on an in-patient basis or as part of an emergency room visit);
- Outpatient or Physician based mental health or substance abuse treatment;
- Human organ transplants;
- Bariatric Surgery (weight loss); and
- Inpatient Surgery.

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

Hospital and Skilled Nursing Facility Stays

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

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

Failure to Contact the Medical Advisor

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

- The name of the person who is hospitalized or who will receive treatment;
- The Hospital's name;
- The reason for the Hospital admission;
- The name and telephone number of the admitting doctor; and
- The diagnosis, if available.

Getting Certification for Other Services

When calling the Medical Advisor, have this information ready:

- The name of the person who will receive the treatment;
- The name and telephone number of the treating Physician; and
- The diagnosis, if available.

Disease Management Program

The Plans also require 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.

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

Special Conditions Regarding the Preferred Provider Organization (PPO)

The Preferred Provider Organization (PPO) is a major feature in the administration of benefits under the Non-Medicare Eligible Retiree Healthcare Plan. The PPO is designed to provide economic incentives for using Providers of health care services who have contracted with the PPO.

Participating Providers are those who have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to balance bill patients in this Plan for Covered Services for amounts in excess of the Maximum Allowance. Therefore, the Covered Person is responsible only for the difference between the Claim Administrator's benefit payment and the Maximum Allowance for the particular Covered Service – generally, that is, the Deductible, and Co-Payment amounts.

The selection of Participating Hospitals by the Claim Administrator will continue to be based upon the range of services, geographic location, and cost-effectiveness of care. The choice of a particular Hospital, however, ultimately is your decision. Moreover, the fact that a Hospital is a "Participating Hospital" is not a recommendation or referral, nor is it a statement as to the ability or quality of such Provider by the Plan or Claim Administrator. Likewise, the fact that a Hospital is a "Non-Participating Hospital" is not a statement as to the Hospital's quality by the Plans or Claim Administrator. Further, neither the Plan, the Plan Sponsor, nor the Claim Administrator will be liable for any act or omission of any Provider.

Warning: Limited Benefits Paid when Non-Participating Providers Used

When a Covered Person who lives in a network area chooses to use the services of a Non-Participating Provider in situations not requiring Emergency Medical Care, Covered Persons may pay more in Co-Payments for such Non-Participating Provider services. In addition, benefit payments for such Non-Participating Provider services are not based upon the amount billed. Instead, the basis for the benefit payment will be determined according to the Maximum Allowance payable to contracted Participating Providers, the Eligible Charge.

Non-Participating Providers may bill Covered Persons for any amount up to the billed charge after the Plan has paid its portion of the bill. That is not the situation with Participating Providers. Instead,

Participating Providers have agreed to accept discounted payments for services with no additional billing to the Covered Person other than Coinsurance and Deductible amounts.

Each Covered Person enrolled in this Plan can find out if a particular Provider participates in the network by asking the Provider or by calling the Claim Administrator. It is always best to ask the Provider before receiving any services not requiring Emergency Medical Care if the Provider is currently a Participating Provider.

Each Covered Person should check with his or her Provider before undergoing treatment to make certain whether network advantages apply. Any Covered Person is free to choose any Hospital or Professional Provider, but the benefits under the PPO will be greater when the services of a Participating Provider are used.

Before reading the description of benefits, please review the terms “Benefit Period” and “Deductible” as defined.

Hospital Benefits

Expenses for Hospital care are usually the biggest of all health care costs. The Hospital benefits provided under the Non-Medicare Eligible Retiree Healthcare Plan can help ease the financial burden of these expensive services. This section describes what Hospital services are covered and how much will be paid toward each of these services.

The benefits of this section are subject to all of the terms and conditions described in this *Retiree Benefit Booklet*. Please refer to the *Definitions* (page 1), *Eligibility, Enrollment, and Termination of Coverage* (page 21), and *Exclusions: What is Not Covered by the Plans* (page 87) sections of this *Retiree Benefit Booklet* for additional information regarding any limitations and/or special conditions pertaining to benefits. In particular, all Inpatient Hospital admissions must be approved by the Plan’s Medical Advisor. See the *Medical Advisor Review Program* section beginning on page 43. Call the Medical Advisor for all Inpatient admissions.

In addition, the benefits described in this section will be provided only for services received on or after the Coverage Date, and when they are rendered upon the direction or under the direct care of a Physician. Such services must be Medically Necessary and charges billed for services must be regularly included in the Provider’s charges.

The level of benefits paid for Hospital Covered Services is generally greater when received in a facility participating in the network.

Inpatient Care

Inpatient Hospital Covered Services are:

Room, board and general nursing care provided within:

- A semi-private room (a private room if Medically Necessary).
- An intensive care unit.

Ancillary services (such as operating rooms, drugs, surgical dressings, and lab work).

Pre-Admission Testing

Benefits are provided for pre-operative tests given on an Outpatient basis.

Inpatient Hospital Benefit

Participating (PPO) Provider Hospital – 90%

Benefits will be provided at 90% of the Hospital's Eligible Charge when Inpatient Covered Services are provided by a Participating Provider after the Deductible has been satisfied, so long as the Inpatient admission is Medically Necessary and has been Certified by the Medical Advisor. For a private room, benefit payments will be limited to the Hospital's rate for its most common type of room with two or more beds.

Non-Participating Provider Hospital Within Network Area – 70%

For Inpatient Covered Services from a Non-Participating Provider within a Covered Person's network area, benefits will be provided at 70% of the Eligible Charge, after the Deductible has been met, so long as the Inpatient admission is Medically Necessary and has been Certified by the Medical Advisor. For a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Non-Participating Provider Hospital Outside Network Area – 80%

For those who live outside a PPO Hospital network area, benefits will be provided at 80% of the Eligible Charge, for Inpatient Covered Services, after the Deductible has been met, so long as the Inpatient admission is Medically Necessary and has been Certified by the Medical Advisor.

Failure to Comply with Medical Advisor Program

To receive maximum benefits under the Plan, an Inpatient admission must be Certified by the Medical Advisor as Medically Necessary. See page 43 for information on when you must call. If you fail to call, you will be subject to financial penalties – you may pay substantially more out of your pocket than if you had called. If you fail to call when required you will pay a \$1,000 penalty.

If the Medical Advisor or Claim Administrator determines that Inpatient care was not Medically Necessary, you will be responsible for 100% of the Hospital bill and all Physicians' charges.

Any expenses you pay for penalties or for care determined by the Medical Advisor to be not Medically Necessary will not be counted toward your Out-of-Pocket Expense Limit.

Emergency Inpatient Admission

Emergency Inpatient admissions also must be approved by the Medical Advisor. In cases of emergency, the Medical Advisor must be called within two business days following an Inpatient Hospital admission.

Benefits for an Inpatient Hospital admission to a Non-Participating Provider resulting from Emergency Accident Care or Emergency Medical Care will be provided at the same payment level that the Covered Person would have received had he or she been in a Participating Hospital for that portion of the Inpatient Hospital stay during which the condition is reasonably determined by the Claim Administrator to be life threatening and therefore not permitting safe transfer to a Participating Hospital or other Participating Provider.

Benefits for an Inpatient Hospital admission to a Non-Participating Hospital resulting from Emergency Accident Care or Emergency Medical Care will be provided at the Non-Participating Hospital payment level for that portion of the Inpatient Hospital stay during which the Covered Person's condition is reasonably determined by the Claim Administrator as not being life threatening and therefore permitting transfer to a Participating Hospital or other Participating Provider.

In some cases, to continue to receive benefits at the Participating Provider payment level following an Emergency Hospital Admission to a Non-Participating Hospital, the Covered Person may be requested to transfer to a Participating Provider as soon as the condition is no longer life threatening. Arrangements to move the patient to a Participating Hospital should begin when the treatment plan begins. The cost of the transfer to a Participating Hospital will be paid by the Plan if the transfer is arranged by the Medical Advisor.

Hospital Benefits Following Childbirth

Under federal law, group health plans 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 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 the Claim Administrator.

Outpatient Hospital Care

The following are Covered Services when received from a Hospital as an Outpatient if they are Medically Necessary.

Surgery and any related Diagnostic Service received on the same day as the Surgery.

Radiation therapy treatments.

Chemotherapy.

Shock therapy treatments.

Renal Dialysis Treatments if received in a Hospital, a Dialysis Facility, or in the home under the supervision of a Hospital or Dialysis Facility. Typically, dialysis services are not provided in home unless it is necessary that they be provided at home or if there is a cost benefit to the Plan to do so. It is not routine to provide home dialysis services.

Diagnostic Service on an Outpatient basis when these services are related to Surgery or Medical Care.

Emergency Medical Care.

Ambulatory Surgical Facility Services as an Alternative to Outpatient Hospital Care

Benefits for surgical Services previously described in this ***Retiree Benefit Booklet*** are available for Outpatient Surgery. Benefits will only be provided if these services are provided in a licensed Ambulatory Surgical Facility. No benefits will be provided for services received at an unlicensed Ambulatory Surgical Facility.

Benefit Payment Level for Outpatient Covered Services/Ambulatory Surgical Facility Services

Participating Provider

Benefits will be provided at 90% of the Eligible Charge after the Deductible has been met when Outpatient Covered Services are received from a Participating Provider Hospital or Ambulatory Surgical Facility.

Non-Participating Provider and Covered Persons Live Within Network Area

When Medically Necessary Outpatient Covered Services are received by a Covered Person who lives within a network area from a Non-Participating Provider, benefits will be provided at 70% of the Eligible Charge, after the Deductible has been met.

Non-Participating Provider and Covered Persons Live Outside Network Area

For those who live outside a PPO network area, benefits for Outpatient Covered Services will be provided at 80% of the Maximum Allowance, after the Deductible has been met.

Emergency Medical Care

Benefits for Emergency Accident Care or Emergency Medical Care will be provided at 90% of the Eligible Charge from either a Participating or Non-Participating Provider.

Benefits for Emergency Accident Care and Emergency Medical Care will be subject to the Deductibles and Co-Payments.

Physician Benefits

This section describes what services are covered and how much will be paid for care from a Physician or other specified Professional Provider.

The benefits of this section are subject to all of the terms and conditions described in this **Retiree Benefit Booklet**. Please refer to the *Definitions* (page 1), *Eligibility, Enrollment, and Termination of Coverage* (page 21), and *Exclusions: What is Not Covered by the Plans* (page 87) sections of this **Retiree Benefit Booklet** for additional information regarding any limitations and/or special conditions.

For benefits to be available under this benefit Section, services must be Medically Necessary and must be received on or after the Coverage Date.

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 Claim 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.

Benefits for oral Surgery are limited to the following services:

- Surgical removal of complete bony impacted teeth.
- Excision of tumors or cysts of the jaws, cheeks, lips, tongue, 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.
- Benefits will also be provided for Anesthesia Services administered by oral and

maxillofacial surgeons when such services are rendered in conjunction with covered, Medically Necessary oral Surgery in the surgeon's office or Ambulatory Surgical Facility.

An opinion sought from a second Physician so that the patient can make a decision about a proposed surgical procedure is covered.

Physician Medical Care

Benefits are available for Medical Care visits as follows:

- Inpatient treatment in a Hospital (or in a Skilled Nursing Facility when Medically Necessary and Certified by the Medical Advisor).
- Patient care for Mental Illness or Substance Abuse (if Certified by the Medical Advisor),
- Home Care Program if pre-Certified by the Medical Advisor.
- Visit to a Physician's office for treatment of illness or injury.

Physician Consultations

Benefits are included for consultations regarding Inpatient treatment in a Hospital or Skilled Nursing Facility if the confinement has been Certified by the Medical Advisor as Medically Necessary. The consultation must be requested by the attending Physician and consist of another Physician's advice in the diagnosis or treatment of a condition that requires special skill or knowledge. Benefits are not available for any consultation done because of Hospital regulations or by a Physician who renders Surgery or Maternity Service during the same admission.

Diabetes Self-Management Training and Education

Benefits will be provided for Outpatient self-management training, education, and medical nutrition therapy if these services are rendered by a Physician, or duly certified, registered or licensed health care professional with expertise in diabetes management. Benefits for such health care professionals will be provided at the Benefit Payment for Other Covered Services. Benefits for Physicians will be provided at the Benefit Payment for Physician Services. Coverage for diabetes self-management training, including medical nutrition education, is limited to:

- Three Medically Necessary visits to a qualified Provider upon initial diagnosis of diabetes by the patient's Physician.
- Two Medically Necessary visits to a qualified Provider if the patient's Physician determines that a significant change in the patient's symptoms or medical condition has occurred. A "significant change" in condition means symptomatic hyperglycemia (greater than 250 mg/dl on repeated occasions), severe hypoglycemia (requiring the assistance of another person), onset or progression of diabetes, or a significant change in medical condition that would require a significantly different treatment regimen.

Diagnostic Service Benefits

Diagnostic Service Benefits will be provided for those services related to covered Surgery or Medical Care. Diagnostic Services must be Medically Necessary. Diagnostic Services will not be paid if the service provided was a routine test or service provided for purposes of a general physical or wellness exam.

Dental Accident Care

Medically Necessary dental services rendered by a Dentist or Physician that are required as the result of an Accidental Injury to sound natural teeth occurring during the Benefit Period. Injuries resulting from chewing or eating are not considered to be Accidental Injuries. Services provided to repair such chewing injuries are not covered by the Plan.

Chemotherapy/Radiation Therapy

Benefits will be provided for Medically Necessary Chemotherapy and radiation therapy treatments.

Benefit Payment Levels for Physician Services

The benefits provided under the Plan for Covered Services will depend on whether services are received from a Participating or Non-Participating Professional Provider within the network Residence Area or from a region outside any network area.

Participating (PPO) Provider Within Network Area – 90%

Benefits will be provided at 90% of the Maximum Allowance after the Deductible has been met when the Covered Services are received from a Participating Provider.

Non-Participating Provider While Living Within Network Area – 70%

For those who live within a network area, benefits will be provided at 70% of the Maximum Allowance, after the Deductible has been met, for Covered Services from a Non-Participating Provider.

Non-Participating Provider While Living Outside Network Area – 80%

For those who live outside a PPO network area, benefits will be provided at 80% of the Maximum Allowance, after the Deductible has been met.

Emergency Physician Care

Benefits for Emergency Medical Care within a network area will be provided at 90% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider after the Deductible has been met. For those who live outside a network area, benefits for Emergency Accident Care or Emergency Medical Care will be provided at 90% of the Maximum Allowance after the Deductible has been met.

PPO Maximum Allowance

The Claim Administrator has contracts with Providers. Providers have agreed to accept the reimbursement schedule offered by the Claim Administrator. For those services received within the PPO network area (without regard to whether the Provider is a Participating Provider), the Maximum Allowance (the maximum amount that will be considered by the Plan as a Covered Charge) is the lowest of the:

- Provider's actual charge; or
- PPO contracted rate.

If you need to learn whether a particular Provider is a Participating Provider, contact the Provider or the Claim Administrator. The Provider will have the most up to date information. Paper directories may not be current.

Other Covered Services

This section describes "Other Covered Services" and the benefits that will be provided for them. Other Covered Services are any Covered Services that are not Hospital Services and not Physician Services and that are specifically described in this *Retiree Benefit Booklet*. Some of the Other Covered Services have special conditions and requirements that apply solely to them. Those special conditions and requirements are described in this section.

- Blood and blood components.
- Braces (leg, back, arm, and neck).
- Outpatient psychiatric services.
- Ambulance Transportation. Benefits will not be provided for long distance trips or 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.
- Chiropractic services. Benefits will be provided for up to 15 visits within the annual Benefit Period for chiropractic care, with a maximum of three modalities per visit. There is no coverage for chiropractic services that are for the purpose of acquiring function or maintaining a level of function where there is no expectation of demonstrable and measureable improvement.
- Durable Medical Equipment (DME).

Benefit Payment Level for Other Covered Services

After the Deductible has been met, benefits will be provided at 80% of the Eligible Charge or 80% of the Maximum Allowance, whichever is less, for most Covered Services that are not classified as Hospital or Physician Benefits, except for Skilled Nursing Facility services. For Skilled Nursing

Facility Services, the Plan will pay 80% of the PPO Maximum Allowance whether the facility is a PPO facility or not.

Special Benefit Provisions

Special considerations apply to the types of treatments described in this section.

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 only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. 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 Covered Person is the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits described in this ***Retiree Benefit Booklet*** will be provided for both the Covered Person and the donor. In this case, payments made for the donor will be charged against the Covered Person's benefits, and will apply to the Lifetime Maximum amount of the Covered Person.

If a Covered Person is the donor for the transplant and no coverage is available to the Covered Person from any other source, the benefits described in this ***Retiree Benefit Booklet*** will be provided for the Covered Person. However, no benefits will be provided for the recipient. Payments made for the donor will be charged against the Covered Person's benefits and will apply to the Lifetime Maximum amount.

The organ transplant benefits described in this ***Retiree Benefit Booklet*** will be provided for the Covered Person in the event that the Covered Person has coverage under another plan but that coverage is not as extensive as the coverage under this Plan, but, if the Covered Person 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 ***Retiree Benefit Booklet***, benefits will not be provided for the following:

- Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital or Skilled Nursing Facility (meaning without interruption and pursuant to a continuous program of care) following recovery from transplant Surgery.
- Services that are not pre-Certified by the Medical Advisor.
- Travel time and related expenses required by a Provider.
- 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.

Cardiac Rehabilitation Services

Benefits for cardiac rehabilitation services are the same as benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Claim Administrator approved programs when these services are rendered within a six month period following an eligible Inpatient Hospital admission for either myocardial infarction, coronary artery bypass Surgery or percutaneous transluminal coronary angioplasty. Benefits will be limited to a maximum of 36 Outpatient treatment sessions within the six-month period. To find out if a program is “approved,” contact the Claim Administrator at the phone number indicated in the *Important Contacts* portion of this ***Retiree Benefit Booklet***.

Skilled Nursing Facility Care

Skilled Nursing Facility Services. Benefits will only be paid for a licensed Skilled Nursing Facility that is a legally operated institution or part of an institution that:

- Is under supervision of a licensed doctor or registered nurse;
- Provides 24-hour a day skilled nursing care on an Inpatient basis;
- Has available at all times the services of a licensed doctor for necessary medical treatment; and Maintains daily records on all patients.

Note: Skilled Nursing does not include any facility or part of a facility that is used primarily for:

- Educational care;
- Custodial Care; or
- Drug abuse or alcoholism care and treatment.

No benefits will be paid for Skilled Nursing Facility Services unless the Medical Advisor has issued prior approval for admission to a Skilled Nursing Facility. Skilled Nursing Facility care that is not approved by the Medical Advisor will not be paid.

Benefits for Covered Services rendered in a Skilled Nursing Facility will be provided at 80% of the Eligible Charge after the Deductible has been met for each Benefit Period. Benefits will be provided based on the PPO payment rate for Skilled Nursing Facility services. Covered Persons will pay less out of Out-of-Pocket Expense Limit if they use a PPO Skilled Nursing Facility.

Mastectomy-Related Services

Benefits are available for Covered Services related to mastectomies, including, but not limited to, 1) reconstruction of the breast on which the mastectomy has been performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas, are the same as for any other condition.

Durable Medical Equipment

Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates, and any other internal and permanent devices as reasonably approved by the Claim Administrator and/or Medical Advisor. These internal and permanent devices will be paid in accordance with the terms of the Hospital benefits.

Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of Durable Medical Equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose. For example, crutches, wheelchairs, and canes are examples of this type of Durable Medical Equipment. These types of Durable Medical Equipment are paid at 80% of the Maximum Allowance amount. Durable Medical Equipment over \$500 (such as wheelchairs), require review by the Medical Advisor.

Prosthetic Appliances

Benefits will be provided for prosthetic devices, special appliances, and surgical implants when they are required to replace all or part of:

An organ or tissue of the human body; or

The function of a non-functioning or malfunctioning organ or tissue.

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders and excluding replacement of cataract lenses when a prescription change is not required).

Home Care Services

Benefits will be provided for certain medical services provided as part of an approved Home Care Plan. The services must be pre-Certified by the Medical Advisor. Only services that are not Custodial Care and that are Medically Necessary will be approved. See the *Definitions* section (beginning on page 1) and *Exclusions: What is Not Covered by the Plans* section (beginning on page 87) for further information.

Limitations on Home Care Services

Home care services do not include:

- Services or supplies not included in the Home Care Plan.
- Services of a family member.
- Custodial Care.
- Food, housing, homemaker services, or home delivered meals.
- Transportation services.

Hospice Care Program

The Plan coverage also includes benefits for Hospice Care Program Services that are pre-Certified by the Medical Advisor. Benefits will be provided for the Hospice Care Program Services described below when these services are rendered by a network Hospice Care Program Provider. Hospice services that are provided by a Non-Participating Hospice Care Program Provider that are pre-certified may be eligible for Participating Provider benefits, if the Medical Advisor coordinates the placement of services in case management. Benefits are available if the Covered Person has a terminal illness with a life expectancy of six months or less, as certified by the attending Physician; and the covered Person will no longer benefit from standard Medical Care or has chosen to receive hospice care rather than standard care.

Prior approval from the Medical Advisor is required for hospice care benefits. The following services are covered under the hospice care program:

- Home Care services.
- Medical supplies and dressings.
- Medication.
- Skilled Nursing Services.
- Occupational Therapy.
- Pain management services.

- Physical Therapy.
- Physician visits.
- Social services.

The following services are not covered under the hospice care program:

- Home maker services.
- Transportation, including but not limited, to Ambulance Transportation, unless approved in advance by the Medical Advisor. (For clinical reasons, ambulance transport may be paid, e.g., short episodes of traditional care, intractable pain, etc.)

Occupational Therapy

Benefits will be provided for Occupational Therapy that is pre-Certified by the Medical Advisor when these services are rendered by a licensed Occupational Therapist acting under the orders of a Physician. Only constructive therapeutic activity designed and adapted to promote the restoration of useful physical function is included in the benefit. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function. There is no coverage for therapy that is for the purpose of acquiring function or maintaining a level of function where there is no expectation of demonstrable and measureable improvement. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency, and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for Outpatient Occupational Therapy will not be allowed unless the care is certified in advance by the Medical Advisor.

Physical Therapy

Benefits will be provided for Physical Therapy when rendered by a licensed professional Physical Therapist under the supervision of a Physician. The therapy must be designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function. There is no coverage for therapy that is for the purpose of acquiring function or maintaining a level of function where there is no expectation of demonstrable and measureable improvement. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency, and duration of therapy and indicate the diagnosis and anticipated goals.

Speech Therapy

Benefits will be provided for Speech Therapy that is pre-Certified by the Medical Advisor, when these services are rendered by a licensed Speech Therapist. The therapy must be designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training or services designed and adapted to develop a physical function. There is no coverage for therapy that is for the purpose of acquiring function or maintaining a level of function where there is

no expectation of demonstrable and measureable improvement. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency, and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for Outpatient Speech Therapy will not be allowed unless the care is certified in advance by the Medical Advisor.

Claim Administrator's Separate Financial Arrangements with Providers

The Claim Administrator, as identified in the Important Contact Information Section, has contracts with certain Providers ("Administrator Providers") in Illinois and other states to provide and pay for health care services to all persons entitled to health care benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under the Non-Medicare Eligible Retiree Healthcare Plan. Pursuant to its contracts with Administrator Providers, under certain circumstances described in its contracts with Administrator Providers, the Claim Administrator may receive substantial payments from Administrator Providers with respect to services rendered to you for which the Claim Administrator was obligated to pay the Administrator Provider; pay Administrator Providers substantially less than their Claim Charges for services, by discount or otherwise; or receive from Administrator Providers other substantial allowances under the Claim Administrator's contracts with them. In negotiating the terms of this 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, Coinsurance, and Co-Payment amounts under this Plan shall be calculated on the basis of the Eligible Charge for services rendered to a Retiree.

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

Example:

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

1. Assume you go into the Hospital for one night and the normal, full amount the Hospital bills for Covered Services is \$1,000. How is the \$1,000 bill paid?
2. You personally will have to pay the Deductible and Coinsurance amounts set out in your *Retiree Benefit Booklet*. Both the Deductible and Coinsurance amounts are based on the Hospital's charges net of any applicable discounts. Assuming a discount of \$300, this amount would be \$700.
3. Assuming you have already satisfied your Deductible, you will still have to pay the Coinsurance portion of the \$700 (the Hospital bill with the discount). For example, if your Coinsurance obligation is 10%, you personally will have to pay 10% of \$700, or \$70.

4. After taking into account the Deductible and Coinsurance amounts, the Claim Administrator will satisfy its portion of the Hospital bill. In most cases, the Claim 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 Claim 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 Hospital bill is \$700 after the discount, your Deductible has already been satisfied, and your Coinsurance is \$70, then the Claim Administrator has to satisfy the rest of the discounted Hospital bill, \$630. However, assuming the Claim Administrator has a contract with the Hospital, the Claim Administrator may be able to satisfy the \$630 bill that remains after your Coinsurance and Deductible, by paying less than \$630 to the Hospital or the Claim Administrator may have to pay more. The Claim Administrator receives, and keeps for its own account, any difference between the amount (based on ADP) paid by the Plan (after your co-pays and Deductible) and whatever the Claim Administrator ultimately pays under its contracts with Administrator Providers, and you are not entitled to any part of these savings.

Here is an illustration of the example:

<i>One day admission</i>	<i>\$1,000</i>
<i>Average discount applied</i>	<i>\$300</i>
<i>Net covered charges</i>	<i>\$700</i>
<i>Deductible (met on previous claim)</i>	<i>-\$0</i>
<i>Amount subject to Coinsurance</i>	<i>\$700</i>
<i>Coinsurance percentage</i>	<i>x 10%</i>
<i>Coinsurance amount</i>	<i>\$70</i>

Other BlueCross BlueShield Separate Financial Arrangements with Providers BlueCard

The BlueCard Program enables BlueCross BlueShield (BCBS) members obtaining health care services while traveling or living in another plan’s service area to receive the same benefits as they do under their contracting plan and access to BlueCard Providers and savings.

BlueCard PPO is a national PPO program that links BCBS PPO Participating Providers and the independent BCBS plans across the country through a single electronic network for claims processing and reimbursement.

The Claim Administrator hereby informs you that other BCBS plans outside of Illinois (“Host Blue Plan”) may have contracts similar to the contracts described above with certain Providers (Host Blue Providers) in their service area.

When you receive health care services through BlueCard outside of Illinois and from a Provider that does not have a contract with the Claim Administrator, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services; or
- The negotiated price that the Host Blue Plan passes on to the Claim Administrator.

Example

Suppose you receive covered medical services for an illness while you are on vacation outside of Illinois. You show your identification card to the Provider to let him or her know that you are covered by the Claim Administrator. This is how the medical service payment would be calculated:

The Provider has negotiated with the Host Blue Plan a price of \$80, even though the Provider's standard charge for this service is \$100. In this example, the Provider bills the Host Blue Plan \$100.

The Host Blue Plan, in turn, forwards the claim to the Claim Administrator and indicates that the negotiated price for the Covered Service is \$80. The Claim Administrator then would base the amount you must pay for the service – the amount applied to your Deductible, if any, and your Coinsurance percentage – on the \$80 negotiated price, not the \$100 billed charge.

So, for example, if your Coinsurance is 10%, you would pay \$8 (10% of \$80), not \$10 (10% of \$100). You are not responsible for amounts over the negotiated price for a Covered Service.

Note: The Coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your Deductible and that there are no Co-Payments associated with the service rendered. Your Deductible(s), Coinsurance and Co-Payment(s) are specified in this Retiree Plan.

Often, this “negotiated price” will consist of a simple discount that reflects the actual price paid by the Host Blue Plan. Sometimes, however, it is an estimated price that factors into the actual price increases or reductions to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care Provider or with a specified group of Providers. The negotiated price also may be billed charges reduced to reflect an average expected savings with your health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for overestimation or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue Plan to use a basis for calculating your liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods in a manner that differs from the usual BlueCard method described above or require a surcharge, the Claim Administrator would calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you receive your care.

Medicare Supplement Retiree Healthcare Plan

Medicare Supplement Benefit Summary

Detailed information on each item appears on the page number provided. Please read the entire document.

Plan Term	Description	See Page(s):
Lifetime Maximum Benefit	\$1,500,000 per person for medical and prescription drug benefits. Includes any amounts paid under either the Non-Medicare Eligible Retiree Plan or the Medicare Supplement Retiree Plan.	70
Plan Deductible for Medicare Part A Inpatient Hospital Services	The Covered Person must pay \$50 of the Medicare Part A Deductible for Inpatient services. The Plan will pay the balance of the Medicare Part A Deductible.	69
Plan Deductible for Medicare Part B Services	\$100 per person for Medicare Part B services (separate from and in addition to Medicare Part B Deductible).	69
Medicare Part B Deductible	The Covered Person must pay the full Medicare Part B Deductible. The Plan will not reimburse for the Part B Deductible.	69
Plan Coverage for Covered Medical Other than Prescription Drugs	The Plan will pay up to 20% of the Medicare allowable amounts after Medicare Part B deductible and Plan Deductible. If a service is not covered by Medicare, the Plan will not pay for the service except for the following exceptions: <ul style="list-style-type: none"> • Care while traveling outside the United States on a temporary basis; or • Prescription Drugs that are covered by the Plan. 	68 75 78
Out-of-Country Services Deductible and Coverage	\$250 per person per year Deductible If you are in a foreign country and are hospitalized due to an emergency, the Plan pays 80% of Eligible Charges for services during the first 60 days of your hospitalization, subject to a \$250 calendar year Deductible. The total lifetime maximum that the City's Plan pays is limited to \$50,000.	75

Plan Term	Description	See Page(s):
Diabetic Supplies	Medicare Part B covers diabetic supplies such as glucose testing monitors, blood glucose test strips, lancets, and glucose control solutions. There may be limits on supplies or how to get them. Ask your pharmacy or supplier if it is enrolled in the Medicare program. If not, Medicare will not pay and neither will the Plan because the Plan is only a supplement to Medicare. If you have paid the yearly Part B deductible as well as the Plan's \$100 annual deductible, the Plan will pay 20% of the Medicare approved amount.	
Prescription Drug Deductible	\$100 per person annually for drugs purchased at a retail Pharmacy (Does not apply to Means Test Eligible Retirees)	78
Covered Person's Share for Prescription Drugs (Cost per mail order prescription will increase 5% per year rounded to the nearest dollar.) Different provisions apply to Means Test Eligible Retirees, see page 103.	<p>For up to a 30-day supply or 100 unit dose (whichever is less) at retail:</p> <ul style="list-style-type: none"> • Generic Drugs: 20% • Formulary Brand Drugs: 20%* • Non-Formulary Brand Drugs: 20% plus \$15* <p>For up to a 90-day supply through Mail Order Prescription Drug Program:</p> <ul style="list-style-type: none"> • Generic Drugs: \$24 in 2013; \$25 in 2014 • Formulary Brand Drugs: \$62 in 2013; \$65 in 2014* • Non-Formulary Brand Drugs: Not Available at Mail <p>* If you receive a Brand Drug when a Generic Drug alternative is available, you will pay the cost difference between the Brand and the Generic in addition to the required generic Co-Payment.</p>	78 78
Generic Step Therapy Program for generics available in the therapeutic class	If you elect to purchase a brand medication without trying an appropriate generic medication in the same therapeutic class, you will pay the full cost of the medication. If you try the Generic Drug and your Physician finds that the Generic Drug is not effective in treating your condition, you will be able to receive the brand medication at the Coinsurance applicable to non-formulary or formulary.	83

Plan Term	Description	See Page(s):
Specialty Drugs	If you do not try the preferred medication for the therapeutic class, you will pay the full cost of the medication. If you try the preferred specialty medication and it is not effective in treating your condition, you will be able to receive a non-preferred formulary drug.	84
Mandatory Mail Order	Requiring the use of mail order will reduce costs for the City and Retirees. After 2 fills of your generic or formulary brand medication at a retail pharmacy, you will be required to use mail order for any additional fills through CVS-Caremark in Mount Prospect, IL. If you do not use the mail order program for your 3rd or any subsequent fills, you will pay the full cost of the prescription. If your medication is non-formulary, however, you must continue to use the retail pharmacy.	83
Out-of-Network Pharmacy Reimbursement	If you do not go to a network retail pharmacy, you pay the full amount when you pick up your prescription. You must then submit a receipt for reimbursement. The Plan will pay 60% of the Plan's cost, after you've met the deductible (if applicable). There is no formulary list if you go to an out-of-network pharmacy.	84

Medical Plan Benefits for Medicare Eligible Retirees and Dependents

This part of the Summary describes medical benefits that will be offered through the Medicare Supplement Retiree Healthcare Plan for Medicare-eligible Covered Persons. This Plan does not apply to Covered Persons with respect to whom the Medicare as Secondary Payer Act requires that Medicare pay secondary to another plan.

Any Covered Person who is eligible for Medicare Part A for free must enroll in Part A of Medicare to receive any benefits under this Plan. In addition, Covered Persons should also enroll in Part B of Medicare to receive the highest level of benefits through this Plan in combination with Medicare.

Some information about Medicare coverage is mentioned in this *Retiree Benefit Booklet*. However, for a complete description of the Medicare program, refer to the Medicare Handbook, that can be obtained from any local Social Security Administration office. Information is also available on the Internet from www.Medicare.gov. To the extent that there is any conflict between the information mentioned in this document and the Medicare laws and regulations, Medicare governs.

The information in this *Retiree Benefit Booklet* about Medicare reflects practices in effect as of July 1, 2013. However, the laws relating to Medicare are amended from time to time.

About Medicare

Generally, people who are at least 65 years old and receiving Social Security or Railroad Retirement benefits, should be eligible for Medicare Hospital insurance (Medicare Part A) with no additional premium payment to Medicare at this time. Additionally, persons who have been entitled to Social Security or Railroad Retirement Board disability benefits for 24 months or persons with Lou Gehrig's disease who are eligible for disability benefits, as well as persons who are kidney dialysis or kidney transplant patients, also should be eligible for free Medicare Part A. Even those who have not contributed to Medicare with their own payroll deductions may be eligible through a Spouse or former Spouse.

Medicare benefits are not automatic – each person must take action to enroll. When a Covered Person reaches the age of Medicare eligibility, the City will notify the applicable Fund to adjust the deductions for coverage and will place the Covered Person in the Medicare Supplement Retiree Healthcare Plan. Claims will be paid as though Medicare were paying primary without regard to whether the Covered Person has timely enrolled in Medicare. In the event a Covered Person does not qualify for Medicare Part A for free, that person must notify the Benefits Service Center in writing on or before the attainment of age 65. Such notice must include the letter from the Social Security office advising the Covered Person of his or her ineligibility for free Medicare Part A. In the event a Covered Person is found not to be eligible for Part A, monthly contribution rates and claims will be adjusted to reflect the Medicare status of the Covered Person. Failure to timely enroll in Medicare when eligible will substantially increase your out of pocket cost for health care services.

Medicare Part A

Medicare Part A covers Hospital, Skilled Nursing Facility, home health care, and hospice care expenses.

Medicare Part B

Medicare Part B covers doctor visits and other medical services. For those who enroll in Part B coverage, the Medicare premium will be deducted from their monthly Social Security checks.

For those who are eligible for Medicare Part A but who do not enroll in Part B coverage, this Plan will only pay benefits as if they were covered by Medicare Part B. In other words, this Plan will not pay benefits in excess of the 20% of the Medicare allowable amount that the Plan would otherwise pay for Part B Covered Persons. In that case, those who decline Part B coverage would be responsible for a significant portion of medical expenses. Thus, it may be better to obtain Part B coverage.

Note: Medicare Part B charges its own monthly premium. The cost of Part B may be increased 10% for each 12-month period that a person does not sign up for Part B after first becoming eligible. The initial enrollment period for Part B coverage begins three months before a person turns 65 and extends through the three months after a person turns 65. If a person does not enroll during the initial enrollment period, then enrollment may take place (but possibly at increased rates) during the general enrollment period any year between January 1 and March 31.

Special Enrollment Rules for Medicare Part B

For those who have been covered as an active employee under an active employee plan after age 65, or for retirees who may be covered as dependents under another's active employee benefit plan, there is a special enrollment period for Part B coverage, which does not involve increased rates. Special enrollment extends during an eight month period following the end of employment or the end of active employee coverage (whichever occurs first). Disabled persons may also qualify for special enrollment. (Note: those persons who retired from City service as Sworn Police or Uniformed Fire and who are eligible for age 60 to 65 coverage must enroll for Medicare as soon as they are eligible. This also applies to their eligible dependents.)

Benefit Period

The Benefit Period is a period of one year, beginning on January 1 of each year and running until December 31. For those enrolling for the first time, the first Benefit Period begins on the Coverage Date and ends on December 31 of the same calendar year. Notwithstanding the preceding, for 2013 only, there is a shortened Benefit Period running from July 1, 2013, through December 31, 2013.

Payment Provisions

Non-Duplication and Conforming with Medicare

This Plan will not duplicate benefits provided by Medicare. In addition, Medicare benefits under both Part A and Part B will determine the benefits each Covered Person is entitled to under this Plan. If actual bills are greater than Medicare-approved charges, the Covered Person will be responsible for the excess. If Medicare denies a claim for an otherwise Covered Service, then no coverage will be available for that service under this Plan.

This Plan will not provide coverage for any service or supply that is not covered by Medicare, except for Outpatient retail and mail order Prescription Drugs and certain Medically Necessary emergency services provided out of country. In addition, this Plan will not provide coverage for any service provided by a Provider or facility that is not Medicare Approved nor will it provide coverage for any Experimental procedures.

Deductibles

This Medicare Supplement Retiree Healthcare Plan has four separate Deductibles, in addition to those of Medicare:

Inpatient Hospital Deductible: The Plan pays all but \$50 of the Medicare Part A Deductible for the first Hospital stay in any calendar year. The Covered Person pays the \$50 amount.

Other Service Deductible: A Deductible applies to Outpatient Hospital expenses and all Physician expenses. This Deductible is \$100 and is in addition to the Medicare Part B Deductible (\$147 for both 2013 and 2014).

- **Out of Country Service Deductible:** For services received while traveling in a foreign country, there is a calendar year Deductible of \$250.

- **Retail Prescription Drug Deductible:** See the *Prescription Drug Program* section on page 78 of this *Retiree Benefit Booklet* for information on Prescription Drugs.

Note: This Plan is effective July 1, 2013. However, you will receive credit towards any applicable Deductibles for any amounts incurred January 1, 2013, through June 30, 2013.

Lifetime Maximum

The total maximum amount of benefits for each Covered Person is \$1,500,000. This is an individual maximum. There is no family maximum.

Cumulative Benefit Maximums

Each Covered Person may receive up to \$1,500,000 in benefits during his or her lifetime while enrolled in the Plan. The lifetime maximum includes benefit payments made on behalf of the Covered Person under either of the Plans (Non-Medicare Eligible or Medicare Supplement Retiree Plans) or the predecessor Annuitant Settlement Healthcare Plans. This maximum also includes benefits paid for Prescription Drugs.

Medicare Part A Supplement Payments

Inpatient Hospital	Medicare	The Plan
<i>Days 1 to 60</i>	Medicare requires a Covered Person to pay a Deductible for a Hospital stay lasting for one through 60 days. The Medicare Part A Deductible is \$1,184 in 2013 and \$1,216 in 2014.	The Plan pays all but \$50 of Deductible for the first hospitalization each calendar year. The Covered Person pays the \$50 for the first hospitalization in each calendar year.
<i>Days 61 to 90</i>	Medicare requires a Deductible of 25% of the Medicare Part A Deductible for each of days 61 through 90. This per day Deductible is \$296 in 2013 and \$304 in 2014.	The Plan pays 100% of the required Medicare Deductible, which is 25% of the Medicare Part A Deductible per day. The Covered Person pays nothing for days 61 through 90.

Inpatient Hospital	Medicare	The Plan
<i>Days 91 to 150</i>	Medicare requires a Covered Person to pay a Deductible of 50% of the Medicare Part A Deductible for each of days 91 through 150. This per day Deductible is \$592 per day in 2013 and \$608 per day in 2014. See <i>Lifetime Reserve Days</i> on page 71.	The Plan pays 100% of the required Medicare Deductible, which is 50% of the Medicare Part A Deductible per day. The Covered Person pays 0% for days 91 through 150.
<i>Days after 150</i>	Medicare usually pays nothing.	This Plan pays 100% of the cost for up to 365 additional days of hospitalization during the lifetime of the Covered Person after the Covered Person exhausts all Medicare benefits.*

* Special Note on Additional 365 Days of Hospital Care Paid by Plan after Medicare Hospital Benefits are Exhausted: These additional Hospital days must be certified as Medically Necessary by the Medical Advisor. Call the Medical Advisor after the 140th day of a Hospital confinement(s) within the same Benefit Period to obtain approval for these extended hospitalizations.

See the rules regarding the Medical Advisor Review Program beginning on page 43.

A Medicare Benefit Period starts the day you enter the Hospital. It ends when you have been out of the Hospital for 60 days in a row. If you re-enter the Hospital within 60 days, the same Benefit Period will continue and you will not have to satisfy a second Deductible. If you are out of the Hospital for at least 60 days in a row and then go back in, a new Medicare Benefit Period starts and a new Medicare Part A Deductible applies. However, the Plan's \$50 Hospital Deductible is only applied to the first hospitalization in a calendar year.

The days paid by the Plan after the Medicare Hospital Benefit is exhausted are paid subject to the contracts that the Claim Administrator has with its Administrator Providers. See information beginning on page 61 for information on the Separate Financial Arrangements that the Claim Administrator has with its Administrator Providers.

Lifetime Reserve Days

The additional coverage offered by this Plan for Inpatient hospitalization is also subject to Medicare's Lifetime Reserve Days program. Lifetime reserve days are the total of 60 days that Medicare will pay for when you are in a Hospital for more than 90 days during a Benefit Period. These 60 reserve days can be used only once during the lifetime of the Covered Person. For each lifetime reserve day, Medicare pays all covered costs except for a daily Coinsurance of 50% of the Medicare Part A Deductible (which is \$592 in 2013 and \$608 in 2014). This Plan would pay the balance not paid by

Medicare so long as the Reserve Days are within the 365 days described above and the Plan's other requirements are met.

Skilled Nursing Facilities (Supplement to Medicare Part A)

Skilled Nursing Facility care is the level of care that requires daily involvement of skilled nursing or rehabilitation staff. Examples of Skilled Nursing Facility care include intravenous injections or Physical Therapy. Needing Custodial Care, such as help in bathing or dressing, does not qualify for Medicare coverage or coverage under this Plan, for Skilled Nursing Facility care. See the definitions of *Skilled Nursing Facility* (on page 19) and *Custodial Care* (on page 6).

Admission to a Skilled Nursing Facility generally should be within 30 days of discharge from a Hospital and must be in accordance with Medicare requirements.

When Medicare Skilled Nursing Facility days are exhausted in a Medicare Benefit Period, this Plan will not pay for any additional days.

Medicare pays 100% of the approved costs for the first 20 days of care in a Skilled Nursing Facility. For days 21 through 100, Medicare pays for the approved costs, less a daily Co-Payment amount of one-eighth of the Medicare Part A Deductible (\$148 per day in 2013 and \$152 per day in 2014). This Plan pays the Skilled Nursing Facility daily Co-Payment for days 21 through 100. However, **days in excess of 100 within a single Medicare Benefit Period are not paid either by Medicare or by this Plan.**

Hospice Care Program Service (Supplement to Medicare Part A)

Hospice Care Program Service is a centrally administered program designed to provide for the physical, psychological, and spiritual care for dying persons (i.e. individuals with a terminal disease and a life expectancy of less than six months) and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and quality of life. Hospice Care Program Service is available in the home, in a Skilled Nursing Facility or in a special hospice care unit of a Hospital.

Currently the Medicare Co-Payment for approved Inpatient hospice care is 5% (this is subject to change). This Plan pays for the Co-Payment amount of Medicare Approved hospice care. Medicare also has a Co-Payment of 5% for drugs or biologicals for each prescription for symptom relief and pain management. This Plan will pay the Co-Payment for these hospice provided Prescription Drugs and biologicals. Contact your Medicare Regional Home Health Intermediary for information on hospice care Medicare coverage.

Physician and Other Medical Services (Supplement to Medicare Part B)

This Plan pays up to 20%, after Deductibles, of Medicare-approved charges after Medicare reimbursement. In many instances the 20% payment will be the remaining balance. However, if the Physician, Provider, or supplier has not agreed to accept "assignment," then the Covered Person may have to pay more or even the entire amount. This Plan will not pay more than 20% of the approved charges, regardless of whether assignment has been accepted.

Once the Medicare Part B Deductible and the \$100 Plan Deductible are met, the following Medicare eligible expenses are paid at a level of up to 20% of the Medicare allowable amount, regardless of whether they are performed as an Inpatient or Outpatient, so long as they are Medically Necessary.

The Plan's payment is limited to 20% of the Medicare allowable charge. No expenses are paid if the expenses are not allowed by Medicare. The only exceptions are the specified payments for Prescription Drugs and the Services Out of the Country as outlined at page 75.

Note: The Covered Person pays the Deductible for Medicare Part B (\$147 for both 2013 and 2014), which is separate from, and in addition to, the Medicare Supplement Retiree Healthcare Plan's Deductible of \$100.

Medicare Part B Covered Expense Examples

Medicare may have requirements related to the frequency or timing or use of the following services. These examples are for illustrative purposes only. This Plan will only provide coverage for a medical service or supply if Medicare has provided coverage for the service or supply. If Medicare has determined that it will not pay for a service or supply, then this Plan will not pay for the service or supply. The following are examples of Medicare Part B Covered Services.

Physician expenses (not routine physical exams).

Outpatient medical services and supplies.

Diagnostic x-ray, laboratory tests.

- Home health care consisting of Medically Necessary services such as skilled nursing care and Physical, Occupational, or Speech Therapy. *Care that is custodial is not eligible for payment as home health care. Medicare has specific criteria for home health care. Please refer to a Medicare handbook for more information.*

Emergency treatment within:

- 72 hours of an Accidental Injury; or
- 24 hours of the onset of a Sudden and Serious Illness.

Chemotherapy, x-ray, radon, and radioisotope treatments for cancer.

Outpatient speech and Occupational Therapy.

Ambulance.

Durable Medical Equipment.

Anesthesia.

Diabetic supplies (see below).

Some drugs or biologicals that are not usually self-administered. This means that coverage is limited to drugs or biologicals administered by infusion or injection; however, if the injection is generally self-administered, it is not covered by Part B. Medicare Part B does not cover most Prescription Drugs. However, Medicare Part B does cover a limited number of Outpatient Prescription Drugs. Specifically, the following are covered: some antigens, osteoporosis drugs, erythropoietin (epogen or epoetin alpha), hemophilia clotting factors, injectable drugs administered by a licensed medical practitioner, immunosuppressive drugs and oral cancer drugs, including some cancer drugs taken by mouth, and oral anti-nausea drugs. Medicare Part B also will cover some drugs used in infusion pumps and nebulizers if considered reasonable and necessary.

Diabetic Supplies for Medicare Eligible Covered Persons

Medicare Part B covers diabetic supplies such as glucose testing monitors, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of testing equipment and test strips. There may be limits on supplies or how to obtain them. Check with the Pharmacy or supplier to find out if it is enrolled in the Medicare program. If it is not, then neither Medicare nor the Plan will pay.

If the local supplier is enrolled in Medicare, and if the yearly Part B Deductible, as well as the \$100 annual Deductible under this Plan, has been paid, then Medicare will pay 80% of the Medicare-approved amount, and the Plan will pay the rest. A Pharmacy may charge the Covered Person for the 20% Co-Payment at the time of purchase, but the Covered Person may then submit that charge to the Plan Administrator for reimbursement. See the *Claim Filing and Claim Appeal Instructions* section, beginning on page 92.

For glucose test strips, all enrolled Pharmacies and suppliers will submit the claim directly to Medicare. If a Covered Person obtains diabetic supplies from a source not enrolled in the Medicare program, or if the Covered Person has not enrolled in Medicare Part B, then this Medicare Supplement Retiree Healthcare Plan will only reimburse up to the amount the Plan would have paid if Medicare had covered the purchase.

Medicare Limit on Professional Charges in Excess of Medicare Allowable Amount

For professional services, such as Physician charges, paid by Medicare Part B, if the Professional Provider does not accept Medicare Assignment, the Professional Provider may collect no more than 115% of the Medicare allowable amount from all sources. For example, if a doctor charged \$200 for an office visit and the Medicare allowable amount was \$100, the doctor could receive no more than \$115 from all sources for the office visit. Please contact Medicare for additional information.

Medical Necessity

For purposes of this Plan, Medicare determines Medical Necessity in accordance with its rules for services subject to Parts A and B of Medicare. Further, the Medicare allowable charge for any service will be the basis of payment for services subject to Parts A and B. For information on Prescription Drugs, see the information beginning on page 78.

Services Out of Country

Medicare does not ordinarily cover health services in a foreign country. If a Covered Person is hospitalized in a foreign country on an emergency basis, then, during the first 60 days of hospitalization, the Plan will pay 80% of the Eligible Charges for Medically Necessary services. Benefits for the services received in a foreign country are subject to a separate \$250 calendar year Deductible. The Covered Person must pay this amount before any charges will be considered by the Plan. The total lifetime maximum that the City’s Medicare Supplement Retiree Healthcare Plan will pay for services received in a foreign country is \$50,000 per individual. Any amount paid for services received in a foreign country will be included in the Covered Person’s Lifetime Benefit Maximum Amount. Claims for services received outside of the United States will be treated as foreign country claims. For services received in a foreign country, see page 12 for a definition of *Medically Necessary* or *Medical Necessity*.

Recovery for Medicare Claims Paid in Error

In the event that a Plan pays eligible claims as primary when the Covered Person has not enrolled in Medicare even though eligible, or when the Covered Person has failed to provide the correct notice of Medicare status, then the Plan Administrator may seek repayment from Medicare and/or the Covered Person (or the Retiree through whom the Covered Person receives coverage) for claims processed incorrectly for the Covered Person. Furthermore, no refunds of contributions will be issued to a Retiree if the Retiree fails to notify promptly both the City and the Pension Fund as to his/her eligibility for Medicare or the eligibility of his/her dependent.

How this Plan Works with Medicare

Here are some examples of the ways in which the Medicare Supplement Retiree Healthcare Plan works in conjunction with Medicare, using 2013 Deductibles:

Service	Total Bills	Medicare Payment	Medicare Supplement Retiree Healthcare Plan Payment	Covered Person
Hospital stay for 10 days	\$19,000	All but the Part A Deductible. For 2013, the Part A Deductible is \$1,184. Medicare pays \$17,816.	All but \$50 of the Part A Deductible. For 2013, the Plan would pay \$1,134.	\$50

Service	Total Bills	Medicare Payment	Medicare Supplement Retiree Healthcare Plan Payment	Covered Person
Surgeon (See <i>A</i> and <i>B</i> below.)	\$6,500	After Part B Deductible, Medicare pays 80% of its allowable amount. In this example, Medicare pays \$5,082.40. (See <i>A</i> below.)	The Plan would apply its \$100 Deductible and then pay the balance of the Medicare allowable amount. In this example, the Plan pays \$1,170.60. (See <i>B</i> below.)	\$247 (\$6,500 less Medicare payment of \$5,082.40 and Plan payment of \$1,170.60.)
<i>Total</i>	<i>\$25,500</i>	<i>\$22,898.40</i>	<i>\$2,304.60</i>	<i>\$297</i>

A: Medicare payment for \$6,500 surgeon’s bill. Assume Medicare allows \$6,500 as its allowable amount. The Part B Deductible must be deducted, and then Medicare pays 80% of the remaining Allowable Amount. (\$6,500 less \$147 equals \$6,353. 80% of \$6,353 is \$5,082.40).

B: Plan payment for \$6,500 surgeon’s bill. The remaining balance of the Medicare allowable amount not paid by Medicare is \$1,270.60 (\$6,353 less \$5,082.40). The Plan pays \$1,170.60 (\$1,270.60 less \$100 Plan Deductible).

Thus, the Covered Person pays \$297 on a total bill of \$25,500. In the examples, each bill represents a Medically Necessary, Medicare-allowable amount. This example also assumes the doctor accepts Medicare assignment. If the doctor did not accept assignment, the Covered Person would be responsible for paying charges in excess of the Medicare allowable amount – this Plan only pays up to 20% of the Medicare allowable amount. For instance, if the surgeon charged \$7,000, Medicare would pay \$5,082.40, this Plan would pay \$1,170.60, and the Covered Person would pay \$747. (\$7,000 less the Medicare payment of \$5,082.40 and the Plan payment of \$1,170.60 equals \$747.)

Deductibles

There is no carryover deductible feature in this Plan; in other words, costs incurred during a previous calendar year do not apply towards the Deductible in the current calendar year.

If you retire in the middle of a calendar year and, before retirement, you were covered by a City-sponsored self-funded health care plan, expenses that counted toward the active employee calendar year Deductible will apply to the Retiree Healthcare Plan medical Deductible. However, the calendar year Deductible for Prescription Drugs purchased at a retail network Pharmacy will have to be met in its entirety with no credit for purchases made while covered under a prior plan.

Limitations

There are some limits on the benefits that will be paid by this Plan. These limitations are in addition to the Exclusions set forth below. These additional limitations include, but are not restricted to:

The Plan will not duplicate payments that would have been made by Medicare if Medicare coverage ends for any reason.

The Plan will not provide payment that would have been made by Medicare were it not for the fact that services or supplies were not received in accordance with its rules and procedures.

If a Covered Person elects not to be covered by Medicare Part B, or elects to discontinue Medicare Part B coverage, this Plan will not provide payment for eligible expenses normally covered by Medicare Part B.

This Plan will not reimburse expenses in excess of Plan limits.

In addition to these preceding descriptions, the general rules, exclusions, and definitions set forth elsewhere in this *Retiree Benefit Booklet* and identified as applying to both Plans are also part of this Medicare Supplement Retiree Healthcare Plan.

Prescription Drug Program

This Section Applies to Both Plans

Overview of the Prescription Drug Program

Prescription Drugs are available at a network of retail locations. Maintenance Prescription Drugs are also available through the Mail Order Prescription Drug Program. All drugs must be Medically Necessary and may only be dispensed if the 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.

Benefit Period

The Benefit Period is a period of one year, beginning on January 1 of each year and running until December 31 of that year. For those enrolling for the first time, the first Benefit Period begins on the Coverage Date and ends on December 31 of the same calendar year.

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; and
- Diabetic supplies, as follows: test strips and lancets.

Benefits for these drugs and supplies will be provided when:

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

Diabetic Supplies are not available under this Prescription Drug Benefit if you are eligible for Medicare. Please see page 86 for information.

Limits on Prescription Coverage

Payments for prescription drug claims are conditioned upon the following:

- The prescription must be Medically Necessary.
- The prescription drug must treat a medical illness or disease.
- The 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 30-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 Administrator requires pre-certification by the Pharmacy Benefit Manager, Claim Administrator, or the Medical Review Advisor for certain drugs or certain uses, including, but not limited to, the following:

- Human growth hormone;
- Thalidomide;
- Lamisil;
- Sporanox;
- Drugs used to treat impotence; and
- Synvisc.

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

The Pharmacy Benefit Manager and the Plan Sponsor reserve the right to limit the number of units filled per prescription for certain drugs or for non-daily dosages. For example, benefits for prescription 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 Pharmacy Benefit Manager and Plan Sponsor reserve the right to determine which drugs will be so limited and to modify at any time such determinations with respect to limits. You will be notified by the dispensing Pharmacy of any applicable limitations.

Drugs will not be dispensed in amounts in excess of the manufacturer’s recommended dosage limits including, but not limited to, length of treatment limits, quantity limits, age limits, gender limits, poly-pharmacy limits or other drug-to-drug interactions that will from time to time be identified by manufacturers.

Prescription drug data will be retrospectively reviewed to determine if there are any atypical or unusual dispensing patterns. If such patterns or atypical results are identified, the Pharmacy Benefit Manager will notify the dispensing Physician of such activity.

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

The Plan will include the amount it spends for Prescription Drugs for a Covered Person in the Lifetime Maximum Expense Limit of \$1,500,000.

The Co-Payments for Prescription Drugs do not contribute to any Out-of-Pocket Expense Limit.

Exclusions from Prescription Drug Benefits

No benefits will be paid for claims on the following Prescription Drugs and/or types of Prescription Drugs:

- Class II narcotics through the Mail Order Prescription Drug Program.
- Retin-A for cosmetic use and for anyone over 19 years of age.
- Botox for cosmetic purposes.
- Any other cosmetic agents,
- Over the counter medications.
- Prescription medications that are available in a non-prescription strength that is medically efficacious.
- Anabolic steroids.
- Prescriptions and/or uses that are not Medically Necessary.
- Contraceptives.
- Non-Prescription Drugs and vitamins.
- Immunizations and inoculations.
- 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.
- Drugs to induce fertility.
- Nutritional Supplements.

- Prescription vitamins, except for prescription strength calcium, potaba, mephyton, and folic acid.
- Any drug or biological for which as prescribed and dispensed or administered to an individual, payments would be available under Parts A or B of Medicare for that individual, even though a Deductible may apply under Medicare. In other words, if a drug or biological is covered by Medicare Part B, then it will not be covered by the Retail or Mail Order Prescription Drug Program (see page 85).
- Non-Formulary prescriptions at mail order

See the *Exclusions from Prescription Drug Benefits* section (beginning on page 80) and the *Exclusions: What is Not Covered by the Plans* section (beginning on page 87) for general exclusions regarding benefits as they also apply to the Prescription Drug Program.

In addition, benefits will not be provided for any refills if the prescription is more than one year old.

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 Prescription Drug Provider” (a Pharmacy that has a contract with the Pharmacy Benefit Manager or PBM) or a “network Pharmacy.” The Pharmacy Benefit Manager selected by the City is listed in the Important Contact Information Section. Contact information for the Pharmacy Benefit Manager is included in the Important Contact Information Section. If you use a Pharmacy that is in the PBM’s network, the Pharmacy will collect your required Co-Payment and you will not have to submit a claim. The network Pharmacy will submit the claim for you and collect only the required Co-Payment. On the other hand, if you use a Pharmacy that is not a network 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 network 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 to 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.

Prescription Program Deductible

There is an annual \$100 Deductible for the Prescription Drug Program that is separate from, and in addition to, the other Plan and Medicare Deductibles. This Deductible is applied to retail Prescription Drugs only; the Deductible does not apply to the Mail Order Prescription Drug Program. A new Deductible period begins on each January 1 thereafter. There is no carryover deductible feature in these Plans.

Types of Prescription Drugs

The benefits received and the Co-Payment amount for drugs will differ depending upon whether they are obtained from a Participating Prescription Drug Provider. These amounts will also 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 or *preferred* drug is a brand name drug that has been designated as a preferred drug by the Pharmacy Benefit Manager. A *brand name* drug is a drug that is protected by trademark registration. The current list of Formulary Drugs (also known as *The Preferred Drug List*) is available on the web-site of the Pharmacy Benefit Manager or by calling the Pharmacy Benefit Manager. The Formulary List may change periodically at the discretion of the Pharmacy Benefit Manager. Such changes are made in part to keep current with new drugs as they become available. Covered Persons 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 Drugs 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 Covered Person 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.

Coinsurance for Retail Prescription Drugs Purchased at a Network Pharmacy

For drugs purchased from a Participating Prescription Drug Provider, each Covered Person must pay a co-payment amount as follows:

Generic Drugs: 20% of the Contracted Cost for each prescription;

Formulary Brand Name Drugs and Diabetic Supplies (when no Generic is available): 20% of the Contracted Cost for each prescription; and

Non-Formulary Brand Name Drugs (when no Generic is available): 20% of the Contracted Cost plus \$15 for each prescription.

Brand Name Drug Purchased when a Generic Drug is Available. If a prescription is filled with a Brand Name Drug when a Generic Drug is available, the Plan will only pay an amount equal to 80% of the Contracted Cost for the Generic Drug. The Covered Person is responsible for 20% of the Contracted Cost for the Generic Drug and the cost difference between the Brand Name Drug and the Generic Drug.

The “Contracted Cost” is the payment rate for Prescription Drugs established in the contract between the City and the Pharmacy Benefit Manager.

Brand Name Drug Purchased When a Generic Drug is Not Available But Other Generic Drugs are Available in the Same Therapeutic Class. If you elect to purchase a Brand Name Drug without trying an appropriate Generic Drug in the Same Therapeutic Class, you will pay the full cost of the medication. If you try the Generic Drug and your Physician finds that the Generic Drug is not effective in treating your condition, you will be able to receive the Brand Name Drug while paying the Co-Payment, as applicable depending on whether the Brand Name Drug is a non-formulary or formulary drug.

Mail Order Prescription Drug Program

For Maintenance Prescription Drugs (those Prescription Drugs you take on a regular basis for a chronic condition), you may also use the Mail Order Prescription Drug Program. The Mail Order Prescription Drug Program allows you to obtain a larger supply of Maintenance Prescription Drugs than is available at a Retail Network Pharmacy. For information about this program, contact the Pharmacy Benefits Manager. The Pharmacy Benefits Manager is listed in the Important Contact Information Section.

How to Use the Mail Order Feature

If you are taking a Maintenance Prescription Drug, 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 Prescription Drugs. 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 Program, you will be notified by the Mail Order Prescription Drug Program. 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.

Mandatory Mail Order

The Plan requires that after 2 fills of your Generic or Formulary Brand Drugs at a retail pharmacy, you will be required to use mail order for any additional fills through the mail order Prescription Drug program. If you do not use the Prescription Drug Mail Order Program for your 3rd or subsequent fills, you will pay the full Prescription Drug cost of the prescription.

Mail Order Prescription Drug Program Co-Payment Amounts

When obtaining Prescription Drugs and diabetic supplies through the Mail Service Prescription Drug Program, each Covered Person must pay a Co-Payment amount of:

Generic Drugs: \$24 for each prescription in 2013/\$25 for each prescription in 2014;

Formulary Brand Name Drug when no Generic Drug is Available: \$62 for each prescription in 2013/\$65 for each prescription in 2014; and

Non-Formulary Brand Name Drugs are not available through the Mail Order Prescription Drug Program.

Brand Name Drug Purchased when a Generic Drug is Available. If you order a Formulary brand drug when generic drug is available, you must pay the generic drug Co-Payment (\$24 for 2013/\$25 for 2014) ***plus*** the cost difference between the brand name drug and the generic drug.

The Mail Order Prescription Drug Program Co-Payment may increase each year.

Specialty Drugs: Specialty Drugs are generally obtained through a specialty pharmacy group within the Pharmacy Benefit Manager. Typically, your Physician, nurse, pharmacy or other provider will inform you if a prescribed medication is a Specialty Drug that must be obtained through the Specialty Drug pharmacy. You also may contact the Pharmacy Benefit Manager with any questions as to what drugs are Specialty Drugs. Typically, Specialty Drugs are used to treat certain complex chronic and/or generic conditions and often come in the form of injected or infused medicines. Specialty Drugs also include certain high cost medicines and medicines that have special storage or delivery requirements (such as refrigeration). If you do not try the preferred medication for the specialty therapeutic class, you will pay the full cost of the medication. If you try the preferred specialty medication and it is not effective in treating your condition, you will be able to receive a non-preferred formulary drug.

Out of Network Prescriptions

An out of network prescription is a prescription that you obtain from a Provider who is not participating in the network (including, for example, a Provider at a Skilled Nursing Facility). You pay the full cost of the prescription and submit a claim form to the Pharmacy Benefit Manager for reimbursement. You must use the claim form provided by the Pharmacy Benefit Manager. Any claim for benefits must include all the required information. Claims submitted for reimbursement are subject to the Retail Prescription Drug Deductible.

Reimbursement Rates for an Out of Network Prescription

In no case will the Plan's payment exceed the amount the Plan would have paid had the prescription been provided by a Participating Provider. The amount of reimbursement you receive will be calculated on the lower of what you paid or the Plan's contracted amount. After the Retail Prescription Drug Deductible has been met, claims will be reimbursed as follows:

Generic Drugs: The Plan will pay 60% of the Contracted Cost for the generic drug; or

Brand-Name Drugs: If a generic drug is not available, then the Plan will pay 60% of the Contracted Cost for the brand-name drug.

Brand Name Drug Purchased when a Generic Drug is Available. If a generic is available, then the Plan will pay 60% of the Contracted Cost for the generic drug.

You will likely pay more out of your pocket for Prescription Drugs if you use a Pharmacy that is not in the network. Here are two examples to show you how the Plan pays for out of network claims:

Example 1

Mary purchases brand name drug X for \$100 out of network. The Plan's contract provides that the price of brand name drug X from a participating Pharmacy would be \$80. No generic equivalent is available. Provided that all other conditions are met, Mary is eligible for a reimbursement of 60% of \$80, or \$48. (Mary previously met her Deductible.)

Example 2

The same circumstances as above, except that a generic equivalent is available, at the Plan's Contracted

Cost of \$40. Then Mary would be reimbursed 60% of \$40, or \$24.

Prescription Drug Coverage for Medicare Eligible Persons

Generally, persons enrolled in the Medicare Supplement Retiree Healthcare Plan will not receive coverage for any drug for which payments would be available under Medicare Part A (meaning drugs prescribed to someone while hospitalized) or Part B for that individual, even though a Deductible may apply under Medicare. See page 69 for more details.

For the drugs covered by Medicare Part B, your Medicare Approved pharmacist or Provider may have to bill Medicare first. This means that you and the pharmacist and or Provider may have to submit certain information to Medicare to determine if the drug will be covered by Medicare Part B after Medicare processes the claim, either you or the Provider may then submit the claim to the Medicare Supplement Retiree Healthcare Plan prescription drug program for payment if Medicare did not cover the drug. If Medicare has denied coverage of the drug, coverage may be available through the Prescription Drug benefit component of this Plan.

Medicare Prescription Drug Coverage

Medicare offers prescription drug coverage through Medicare prescription drug plans. Individuals entitled to Medicare Part A or enrolled in Medicare part B can enroll for Medicare Prescription Drug Coverage (Medicare Part D) when they are first eligible for Medicare or between October 15 and December 7 each year.

As long as the City's prescription drug benefits are creditable coverage, you can choose to stay covered under the City's Plan and join a Medicare plan later and not be subject to the higher Medicare premium penalty. Regardless of whether or not you or a dependent enroll for Medicare Prescription Drug

Coverage, you will continue to receive your current prescription drug benefits under the City's Plan (as long as you or your dependent are otherwise eligible to continue the City's coverage).

You may request a copy of the Plan's Notice of Prescription Drug Creditable Coverage at any time from the Benefits Service Center.

Diabetic Supplies for Medicare Covered Persons

Diabetic supplies are not covered by the Prescription Drug Program of the Medicare Supplement Retiree Healthcare Plan. Medicare Part B covers diabetic supplies such as glucose testing monitors, blood glucose test strips, lancet devices and lancets, and glucose control solutions. See page 86 for details.

Diabetic Supplies for Non-Medicare Plan Covered Persons

For those enrolled in the Non-Medicare Eligible Retiree Healthcare Plan, benefits for diabetic supplies are provided through the Mail Order Prescription Drug Program only.

Exclusions: What is Not Covered by the Plans

This Section Applies to Both Plans

- Hospitalization, services, supplies, or treatments that are not Medically Necessary.

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

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of the Claim Administrator or Medical Advisor, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition.

The Claim 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 Non-Medicare Eligible Retiree Healthcare Plan, and, with respect to Hospital Inpatient days after exhaustion of Medicare benefits under the terms of the Medicare Supplement Retiree Healthcare Plan, as described on page 70.

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

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

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

- Services or supplies that are not specifically mentioned as a Covered Service in this *Retiree Benefit Booklet*.
- Charges for services or supplies above the Maximum Allowance.

- Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any workers' compensation law or other similar laws whether or not a claim is made for such compensation or such benefits are received.
- Services or supplies for an illness or injury that is covered under workers' compensation or similar law.
- Services or supplies for any illness or injury incurred in the course of or arising out of any employment (including self-employment or contracted employment) without regard to whether benefits are available under any workers' compensation law or other similar laws.
- Services or supplies that are furnished by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits 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 and supplies for any illness or injury occurring on or after the Coverage Date as a result of war or an act of war.
- Services or supplies that do not meet accepted standards of medical and/or dental practice.
- Charges for drugs, devices, procedures, services, supplies, or medical treatments that are considered Experimental or Investigational by generally accepted medical practices.
- Custodial Care services or supplies.
- Charges for services in a nursing home and/or sanitarium other than a Skilled Nursing Facility.
- Routine physical examinations, unless otherwise specified in this *Retiree Benefit Booklet*.
- Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions that are not specifically the result of Mental Illness.
- Cosmetic Surgery and related services and supplies, except:
 - Operations necessary to repair disfigurement due to an accident that occurs while you are covered by this Plan;
 - The Medically Necessary treatment of a Congenital Anomaly in an eligible dependent child who is covered by this Plan;
 - For reconstructive breast Surgery if a mastectomy has been performed while

covered under this Plan;

- For operations necessary to repair disfigurement due to surgical treatment of an illness if such operation improves or restores bodily function and the surgical treatment was covered by the Plan.
- 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 occurring while covered under this Plan. For purposes of this exclusion, injury to teeth due to chewing or biting food are not covered; and
 - Inpatient Hospital charges for oral Surgery while a registered patient if Medically Necessary.
- 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 Covered Person is not required to make payment or would have no legal obligation to pay without this or similar coverage.
- Charges for failure to keep a scheduled appointment or charges for completion of a Claim form.
- Charges for interest or taxes on an unpaid claim.
- Charges for any telephone, Skype, internet, or e-mail consultations or for a medical record.
- 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, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this *Retiree Benefit Booklet*.
- Vision therapy or orthoptics.
- Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this *Retiree Benefit Booklet*.

- Charges for Chiropractor visits in excess of 15 visits per year or in excess of three modalities per visit.
- Surgical correction of refractive errors (for example, surgical correction of nearsightedness or farsightedness).
- Treatment of flat foot conditions and the prescription of supportive devices, 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.
- Immunizations and inoculations.
- Penalties for not complying with the Medical Service Advisor program.
- Maintenance Occupational Therapy, Maintenance Physical Therapy, and Maintenance Speech Therapy.
- Hearing aids or examinations for the prescription or fitting of hearing aids.
- Diagnostic Service as part of routine physical examinations or check-ups unless otherwise specified herein as a Covered Service, premarital examinations, determination of the refractive errors of the eyes, , surveys, case finding, research studies, screening, or similar procedures and studies, or tests that are Investigational, unless otherwise specified in this ***Retiree Benefit 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 a disease or injury.
- Wigs (also referred to as 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 ***Retiree Benefit Booklet***.
- Non-Prescription Drugs other than insulin.
- Acupuncture, naprapathy, or services provided by an acupuncturist or a naprapath.
- Residential treatment centers.
- Temporary residential treatment in a camp setting.
- Treatment or classes for smoking cessation, including patches, hypnotism, Prescription Drugs, etc.

- Health club charges or fees.
- Well-baby care, except for Inpatient Hospital nursery care immediately following the birth of a covered dependent.
- Retainers, mouth guards, dental exams, prophylaxis, and orthodontia for any Temporomandibular Joint (TMJ) Dysfunction and Related Disorder.
- Dental implants or expenses related to the preparation of the mouth for dental implants.
- Replacement of teeth lost as a result of medical treatment.
- Nutritional therapy or nutritional supplements.
- Services rendered by an immediate family member.
- Genetic testing.
- Co-Payments for Prescription Drugs.
- Charges related to an intentionally self-inflicted injury or illness while sane or insane.
- Outpatient Occupational and Speech Therapy to acquire function or to maintain a level of functioning for a person who has not previously reached the level of intellectual, speech, motor or physical development normally expected for the Covered Person's age, including Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation.
- Marital, cognitive, investigational, educational, or family therapy.
- Biofeedback treatment.
- Reversal of voluntary sterilization procedures.
- Gender reassignment or related services or supplies.
- Private Duty Nursing.
- Applied behavioral analysis.

Claim Filing and Claim Appeal Instructions

This Section Applies to Both Plans

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

Special Instructions Regarding Medicare Claims

When you receive your Explanation of Medicare Benefits (EOMB), you may see this message, “This information is being sent to your Supplemental Insurance Carrier for further consideration.” You do not need to file a separate claim with the Claim Administrator. If this message does not appear on your Explanation of Benefits, then you must send a copy of your Medicare Explanation of Benefits to the Claim Administrator for your claim to be processed.

Note: In the event you are eligible for Medicare but have not enrolled in Medicare, the amount that would have been available from Medicare, had you enrolled, will be estimated and deducted from your Eligible Charge.

When sending bills for processing, be sure to include the following information:

- The name of the patient;
- The name and Unique Identification Number of the Retiree, Surviving Spouse Annuitant, or Child Annuitant;
- The date and charge for each service rendered;
- The diagnosis, type of illness or injury for each charge;
- The type of service or treatment provided; and
- The name, address, phone number, and tax identification number of the Provider.

Hospital Bills

Normally, the Hospital will send the bill to the Claim Administrator directly. If the bill is sent to the Covered Person, however, the Covered Person then must send a completed claim form and the Hospital bill to the Claim Administrator as identified in the Important Contact Information Section.

Non-Hospital Bills

Participating Providers bill the Claim Administrator directly. However, if you live in the Chicago area but use a Non-Participating Provider, you will need to send a completed claim form and the bill to the Claim Administrator as identified in the Important Contact Information Section.

For those who live outside the Chicago area, but in an area where local health care Providers belong to a PPO network, claims that are not submitted by Providers directly should be sent to the local PPO network office. The address will be provided by the Claim Administrator along with the local PPO network information or may be obtained by calling or contacting the Claim Administrator.

Completing the Claim Form

Be sure to include your full name and Unique Identification Number with all claims. The City contract numbers should be included on the claim form. The group number is on your Plan identification card and will be required on the claim form.

Note: Send claims directly to the Claim Administrator as indicated in the Important Contact Information Section. Do not send bills or claims to the Benefits Service Center or Benefits Management Division.

Where to Get Claim Forms

A supply of claim forms is sent to each Retiree, Surviving Spouse Annuitant, or Child Annuitant after enrollment. Forms may also be obtained from the Claim Administrator as indicated in the Important Information Section

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 provisions applicable to claims. Nonetheless, the Benefits Service Center will give all such inquiries due consideration and attempt to address them in a timely fashion. Additionally, the Plan does provide for review of such determinations.

Providing Notices

Any information or notice that must be furnished to the Claim Administrator under the Plan as described in this ***Retiree Benefit Booklet*** must be in writing and sent to the Claim Administrator, as identified in the Important Contact Information Section.

Time Limits for Filing Claims

Claims must be filed with the Claim Administrator on or before December 31 of the calendar year following the year in which the Covered Service was rendered. (A Covered Service furnished in the last month of a particular calendar year shall be considered to have been furnished the succeeding calendar year.) Claims that are not filed within the required time period will not be eligible for payment. Payment of Claims and Assignment of Benefits

The Plan has delegated to the Claim Administrator the responsibility for the initial benefit determination and for reviewing and deciding certain appeals.

Under this Plan, the Claim Administrator has the right to make any benefit payment either to the Covered Person or directly to the Provider of the Covered Services. For example, the Claim Administrator may pay benefits to the Covered Person if the Covered Services are received from a Provider who is not part of the network.

A Covered Person's claim for benefits under this Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at any time before or after Covered Services are rendered to a Covered Person.

Coverage under this Plan is expressly non-assignable and non-transferable and will be forfeited if a Covered Person attempts to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void. Moreover, the Plan shall be entitled to recover from the Covered Person (including by means of offset against future benefits) any claims mistakenly paid due to a wrongful attempt to assign or transfer or otherwise procure coverage.

Provider Relationships

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

The Claim Administrator does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services. Neither the Claim 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 be legally performed by a Provider are not provided by the Claim Administrator. Any contractual relationship between a Physician and a Provider shall not be construed to mean that the Claim Administrator is providing professional service.

The Plan may describe a Provider as "participating," "preferred," "in-network," or "approved," but this should in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. Likewise, the omission or non-use of these terms should not be construed as carrying any statement or inference, negative or positive, as to skill or quality of such Provider.

Information and Records

It is the Covered Person's 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 (such as a medical history) or any information relating to (a) any Illness or Injury for which a Claim is made under the Plan, or (b) 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 or Claims, furnishes or otherwise take steps to make available (such as signing any necessary authorization forms) to the Claim Administrator or its agent, any and all information and records (including copies of records) relating to such Illness, Injury, Claim or Claims, at any time upon the Claim Administrator's request.

In addition, the Claim Administrator may furnish similar information and records (or copies of records), in accordance with HIPAA (see information beginning on page 106, to Providers, other PPO network plans, insurance companies, governmental bodies or programs or other entities providing insurance-type benefits requesting the same. It is also the Covered Person's responsibility to provide the Claim Administrator and/or the City Benefits Service Center information regarding eligibility of any Covered Person for Medicare, termination of Medicare eligibility so that the Claim Administrator may be able to make Claim Payments in accordance with applicable laws.

If a Claim is Denied

If all or part of a claim is denied, a Covered Person may challenge the decision by sending a written request for review within 90 days after notification of the denial to the Claim Administrator

If the Covered Person is not satisfied with the decision of the Claim Administrator upon appeal, then a further appeal of the decision may be made by sending a written request for review to the City Benefits Manager. All disputes regarding claim denials must be delivered via hand-delivery or placed in the mail to the Benefits Manager at the address listed below within 30 days of the denial of the appeal by the Claim Administrator.

If the City of Chicago Benefits Manager, or his or her designated representative, determines that the Covered Person is not eligible to participate in the Plan, or otherwise is not entitled to benefits, the Covered Person or the Retiree, Surviving Spouse Annuitant, or Child Annuitant, will be notified. A written notice will be given shortly after the denial of eligibility or denial of claim and will include the reason for the denial and a statement of the right to appeal the denial to the Benefits Committee. The appeal to the Benefits Committee must be delivered or postmarked no later than 30 calendar days after the date of the notice of denial by the Benefits Manager.

Those who disagree with the denial of eligibility or a claim by the Benefits Manager may send a written appeal to:

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

The appeal should include a brief statement of the reason the denial is believed to be wrong. It should also include any additional information that would help the Committee in reviewing the claim 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 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 Plan, and no benefits will be paid unless the Benefits Committee or its authorized representative (i.e., the Claim Administrator) has determined that a claimant is entitled to them.

Combining with Other Coverage or Coordination of Benefits (COB)

Many individuals have medical coverage in addition to the coverage available under these Plans. For example, a City retiree may be covered as a dependent under his or her Spouse's plan. Coordination of Benefits (COB) applies when a Covered Person has health benefit coverage through more than one group program. The purpose of COB is to recover for the Covered Person all the benefits to which he or she is entitled.

However, the Covered Person will not receive in total more than the actual cost of the care that was provided. The maximum amount payable by this Plan is limited to the amount that would have been paid if there were no other plans involved.

Each Covered Person is required to notify the City of Chicago upon initial enrollment in this Plan if he or she is covered by any other health benefit plan. The Claim Administrator may send each Covered Person a COB 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 plans will be coordinated with the City's Plans:

- No-fault automobile insurance plans;
- Health Maintenance Organizations (HMO);
- Other group health care plans or plans covering individuals as members of a group;
- Medical Care components of long-term care contracts, such as skilled nursing care;
- Medical benefits under group or individual automobile contracts;
- Group Hospital service prepayment plans;
- Group medical service prepayment plans;
- Group practice or other group prepayment coverage;
- Government programs including Medicare; and
- Medicare Supplement Retiree Healthcare Plan Policies.

How COB 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 may pay the difference between benefits paid from the primary plan and the benefits payable by this Plan. ***The total benefits paid will not be more than what would have been paid if this Plan were primary.*** Allowable expense is a health care expense, including Deductibles, Coinsurance, and Co-Payments, that is covered at least in part by any plan covering the person. When a 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 plan covering the person is not an allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

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 is not an allowable expense.

The amount of any benefit reduction by the primary plan because a Covered Person has failed to comply with plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, pre-certification of admissions, and Participating Provider arrangements.

Order of Benefit Determination Rules

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

- The primary plan pays or provides its 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 commencing 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 Subparagraph (a) (the birthday rule) above shall 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 Subparagraph (a) above shall 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; and 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 of Subparagraph (a) or (b) above shall 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, that is, 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 of 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 COBRA 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.
- *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 of time is the secondary plan.

If the preceding rules do not determine the order of benefits, the allowable expenses shall 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.

Effect on the Benefits of this Plan

The Plan will pay benefits when the Plan is the primary plan. When the Plan is the secondary plan, it may pay the difference between benefits paid from the primary plan and the benefits payable by the 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 these COB rules and to determine benefits payable under this Plan and other plans. So long as it acts in compliance with the HIPAA Privacy Rule as discussed beginning on page 106, the Claim Administrator may get the facts it needs from or give them 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 Claim Administrator need not tell, or get the consent of, any person to do this. Each

person claiming benefits under this Plan must give the Claim Administrator any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Claim Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Claim Administrator will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by the Claim Administrator is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services. Such recovery may include offsetting against future benefit payments any excess payments made to a Covered Person.

COB and Medicare

For Medicare eligible Covered Persons, for Prescription Drug and foreign travel benefits, the rules of Coordination of Benefits described above shall apply without modification.

Notwithstanding the above stated rules for Coordination of Benefits, for Covered Persons under the Medicare Supplement Retiree Healthcare Plan, Medicare is always the primary payer for services subject to Medicare.

If a Covered Person’s Spouse has coverage under more than one group plan that pays secondary to Medicare, the above described rules for Coordination of Benefits will apply in determining the payment order for payment by the supplemental benefit plans after Medicare has paid as primary.

In no case will the Plan make a payment if the combination of Medicare’s primary payment and another plan’s payment as the secondary coverage payment equal the total amount of the Medicare allowable amount. It is unlikely that a payment will be made if this Plan is paying as the third payer. For example, if the Spouse of a Retiree has Medicare Supplement Retiree Healthcare Plan coverage from a prior employer, then Medicare would be primary and the Spouse’s coverage as a Retiree with her former employer would pay secondarily. This Plan would be the third payer and it is unlikely that the Plan would make a payment for such Medicare Covered Services.

Similarly, if a Covered Person has coverage as an active employee (with an employer other than the City of Chicago) and also has coverage as a Medicare Eligible Retiree, then this Plan will pay in the third position following the active employee coverage and Medicare. In addition, as described above, if this Plan is the third payer, it is unlikely that a payment will be made.

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 “Covered Person”) may have arising out of the Injury. The Plan’s subrogation rights include, without limitation, all rights of recovery a Covered Person 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 Covered Person 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 Covered Person 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 Covered Person’s attorney shall be paid first from any recovery by or on behalf of a Covered Person, and the amount of the Plan’s subrogation claim shall be paid next from such recovery. Neither a Covered Person 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 before the payment of the Plan’s subrogation claim.

The Covered Person 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 before the time an injury-related payment or settlement is made to or for the benefit of the Covered Person. If the Covered Person 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 Covered Person 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 Covered Person for any otherwise covered claim incurred by the Covered Person 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 incurred by or on behalf of a Covered Person in connection 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 Covered Person is contingent on both the Covered Person's full compliance with the Plan's provisions, including the subrogation provision, and when the Plan deems appropriate, the Covered Person signing a reimbursement agreement. However, the Covered Person'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.

Audits and Refunds

Carefully review bills from Hospitals, Physicians and other medical Providers. If a Covered Person finds an error on a bill and gets the bill corrected, and the money recovered by the Plan is at least \$10, a payment for 25% of all Funds recovered by the Plan will be issued up to a maximum of \$500, except that Payment for an error resulting from the misplacement of a decimal point will be limited to \$250.

If you know of a Covered Person presenting bills for services that have not been received or for a dependent who is not eligible, please notify the Benefits Management Division in writing. The Benefits Management Division or Claim Administrator will pursue an investigation.

Right of Recovery

The Plan shall be entitled to recover (including by means of offset against future benefits) from the Covered Person or from the Retiree through whom the Covered Person has coverage any excess payments paid due to mistake or fraud or any other reason.

Means Test

This Section Applies to Both Plans

A Retiree, Surviving Spouse Annuitant, or Child Annuitant may apply each year to have a cap on monthly contribution rates and certain Co-Payment provisions, provided that the combined household adjusted gross income of the Retiree's family, as reported to the Internal Revenue Service in the immediately preceding tax year, is at or below 250% of the federal poverty guidelines for the family size of the Retiree for that year. The Retiree and household family members must provide a signed, Internal Revenue Service release form to the Benefits Service Center. The Benefits Service Center will then obtain the applicable tax return information from the Internal Revenue Service.

However, those former City employees who retire and/or commence receipt of an annuity on or after July 1, 2005, and whose retirement annuity is based upon less than 10 Years of City Service credits, including those who are receiving reciprocal annuities, must pay the full cost of coverage and may not apply for any reductions in Co-Payments or monthly contribution rates under the Means Test.

For those whose tax records demonstrate qualification under the Means Test, the following differences will apply for that year: Monthly contribution rates will be capped at 25% of the total household adjusted gross income, if the total household adjusted gross income is greater than 200% and less than or equal to 250% of the federal poverty guidelines income amount.

Monthly contribution rates will be capped at 20% of the total household adjusted gross income, if the total household adjusted gross income is greater than 150% and less than or equal to 200% of the federal poverty guidelines income amount.

Monthly contribution rates will be capped at 15% of the total household adjusted gross income if the total household adjusted gross income is greater than 100% and less than or equal to 150% of the federal poverty guidelines income amount.

Monthly contribution rates will be capped at 10% of the total household adjusted gross income if the total household adjusted gross income is less than or equal to 100% of the federal poverty guidelines income amount.

In addition to these monthly contribution rate caps, those whose combined household adjusted gross income is 250% or less of the federal poverty guidelines income amount as determined by the analysis of the Internal Revenue Service tax return document, will be allowed to pay the following reduced prescription benefit Co-Payments for the year:

- Mail Order Prescription Drug Program Co-Payments will be \$7 for generic drugs, and \$20 for Formulary brand name drugs without a yearly increase so long as the Retiree, Surviving Spouse Annuitant, or Child Annuitant continues to qualify under the Means Test set forth above. Non- Formulary Brand-named drugs are not available through the Mail Order Prescription Drug Program.
- For retail drugs, the \$100 retail prescription drug Deductible will not apply in any year for which the Retiree, Surviving Spouse Annuitant, or Child Annuitant qualifies under the Means

Test.

Contact the Benefits Service Center for details about this program or for an application. The Benefits Service Center will send a new application to those who are currently receiving any benefit under the Means Test each year.

Amendment and Termination of Plans

This Section Applies to Both Plans

With respect to Retirees who retired before August 23, 1989, the City will continue to offer the Plans indefinitely. With respect to Retirees who retired on or after August 23, 1989, the City will continue to offer the Plans through December 31, 2016, at which time, all coverage under the Plans will cease for these individuals. Additionally, with respect to either group of Retirees, the City may modify the benefits in any way for any reason at any time in its sole discretion. Also, the City reserves the right in its sole direction to modify Retiree contribution rates at any time and for any reason.

HIPAA Information

This Section Applies to Both Plans

This section discusses the Privacy, Portability, and Security rules contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

HIPAA Privacy

This summary describes the circumstances under which the City of Chicago, 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 Covered Persons' rights to access and control PHI.

PHI is information about a Covered Person, including demographic information, collected from a Covered Person or created and received by a health care Provider, a health plan, an employer, of a health care clearinghouse and that relates to the Covered Person's: (i) past, present or future physical or mental illness or condition; (ii) receipt of health care; or (iii) past, present or future payment for the provision of health care.

The City, through its Benefits Service Center, 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 Claim Administrators to process claims for Covered Persons. The City's Benefits Service Center does not store claim records.

Permitted Uses and Disclosures

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

- **Payment.** Payment refers to the activities involved in the collection of premiums (monthly contributions) and the payment of claims under the plans for the services provided. Third parties, including pension funds and the Claim Administrator, 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 Covered Person and is subject to the 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

Federal law also allows a group health plan to use and disclose PHI, without consent or authorization, in the following ways:

- To the Covered Person;
- To a personal representative designated by a Covered Person 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 the 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.
- **Access to PHI by Covered Persons.** The Plan Sponsor will make PHI available to the Plan to permit Covered Persons upon request to inspect and copy their PHI to the extent provided by 45 C.F.R. § 164.524.
- **Amendment of PHI.** The Plan Sponsor will make PHI available to Covered Persons 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 C.F.R. § 164.526.
- **Accounting of PHI.** The Plan Sponsor will make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 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 for the purpose of determining 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 or 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 requirements set forth herein, such persons shall 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 shall take whatever actions necessary to resolve such noncompliance. Regardless of whether a person is disciplined, terminated or removed pursuant to this paragraph, the Plan reserves the right to direct that Plan Sponsor modify or revoke any person's access to or use of PHI, and Plan Sponsor shall take such action as warranted. Anyone who suspects an 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.

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 C.F.R. § 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, “security incident” is defined as the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.