

CITY OF CHICAGO

MEDICAL AND DENTAL PLAN SUMMARY GUIDE FOR 2011

For Non-Represented Employees, and for Employees covered under the City's collective bargaining agreements with: AFSCME, Coalition of Unionized Public Employees (Chicago Building Trades Coalition), INA, Unit II, Police Captains Association, Police Lieutenants Association, and Police Sergeants represented by the Policemen's Benevolent & Protective Association of Illinois (PB&PA).

PPO MEDICAL PLAN COMPARISON



BlueCross BlueShield of Illinois

1-800-772-6895

www.bebsil.com

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			PP0		
			In-Network	Out-of-Network	
MEDICAL BENEFITS					
The Plan pays the following percen	tage of PPO allowable charges after you i	meet the calendar yea	r deductible.		
Individual Deductible Each Year			\$350	\$1,500	
Family Deductible Each Year			\$1,050	\$3,000	
Individual Out-of-Pocket Limit Each	ı Year		\$1,500	\$3,500	
Family Out-of-Pocket Limit Each Ye	ar		\$3,000	\$7,000	
Network and Non-Network Provider benef	its cannot be combined; does not include prescr	iption copayments			
WELLNESS BENEFITS					
Routine Physical Checkups (Adults		100% of r	100% of maximum allowable charges up to \$600 per covered individual, per year Annual routine pap smear, mammogram, PSA and DRE are payable at 100% of the PPO allowable charges, and do not apply toward the		
Routine Pediatric Checkups, Well B	aby Care [Immunizations]				
Routine Lab Work		at 100% of the			
Hearing Screenings		3.2 100 /0 01 1.110	Wellness Benefit	limit.	

Hearing Screenings	Wellness Benefit limit.	
OUTPATIENT PHYSICIAN SERVICES	0	0%
Ambulance Transportation between Hospitals ⁽¹⁾ Office Visits	3	U /0
Diagnostic Testing (e.g., X-ray, lab, etc.) Outpatient Surgery		
Physical Therapy		60%
MRI Scans, Pet Scans, CAT Scans ⁽¹⁾	90%	
Chiropractic Visits (maximum 20 per year; three modalities per visit)	90%	
Durable Medical Equipment (DME) (over \$500)(1)		
Skilled Home Health Care and Hospice Care ⁽¹⁾ Infertility Treatment ⁽¹⁾		
Occupational and Speech Therapy ⁽²⁾	\$20 copay balance payable at 100%	
HOSPITAL		
Room and Board (Private room is covered If medically necessary) Number of days (Subject to Medical Necessity) Inpatient Hospital Services Outpatient Hospital Services Skilled Nursing Facility (1)	90%	60%
MATERNITY		
Maternity (delivery (1), prenatal visits, and postnatal visit)	90%	60%

Important Note: If you were hired on or after January 1 2006, you are not eligible to change your medical or dental plan until the first Open Enrollment Period following 18 months of your City of Chicago date of hire.



RICHARD M. DALEY, MAYOR

CITY OF CHICAGO



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	In	-Network	Out-of-Network
ORGAN TRANSPLANTS			
The following organ transplants must be performed at a "Center of Distinction" netwo	rk location or they are not covered. You must ca	all Encompass at 1-	800-373-3727 for pre-certifica
Heart ⁽¹⁾⁽⁴⁾			
Combination Heart/Bilateral Lung ⁽¹⁾⁽⁴⁾			
Simultaneous Pancreas Kidney ⁽¹⁾⁽⁴⁾			
Kidney only in conjunction with SPK/PAK(1)(4)		90%	Not
Bone Marrow ⁽¹⁾⁽⁴⁾			Covered
Stem Cell (autologous and allogeneic)(1)(4) Lung(1)(4)			Govorod
Liver ⁽¹⁾⁽⁴⁾			
Pancreas (PAK/PAT)(1)(4)			
All Other Organ Transplants ⁽¹⁾		90%	60%
BARIATRIC SURGERY		0070	0070
Bariatric surgery must be performed at a "Center of Distinction" network location	or the surgery is not covered, You must call	Encompass at 1-80	DO-373-3727for pre-certificat
Bariatric Surgery ⁽¹⁾⁽⁴⁾		90%	Not Covered
EMERGENCY			
Emergency Room Copayment \$100 per visit; waived if admitted as an in-pa	tient ⁽¹⁾ . The copayment does not apply to	ward the Deducti	ble or Out-of-Pocket Limit.
Emergency Medical or Emergency Accident Care	, , , , , , , , , , , , , , , , , , , ,	90%	90%
MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT			
Outpatient Mental Health and Substance Abuse(3)		90%	60%
PRESCRIPTION DRUGS			
etail (Short term medications Maintenance or long term	Generic: \$10.00 co-pay		
medications - less than 4 refills) Purchased at a participating	Brand Name (Formulary): \$30.00 co-pay*		
pharmacy 34-day supply or 100 units, whichever is less)	Brand Name (Non-Formulary): \$45.00 co-pay		
etail (Maintenance or long term medications) - 4th refill and any	Generic: \$20.00 co-pay		
additional refills 34-day supply or 100 units, whichever is less	Brand Name (Formulary): \$60.00 co-pay* Brand Name (Non-Formulary): \$90.00 co-pay*		
fail Order (Long-term medications for chronic conditions; 90 day supply)	77 :	uu co-pay^	
ian order (Long-term medications for chronic conditions, 90 day supply)	Generic: \$20.00 co-pay Formulary Brand: \$60.00 co-pay*		
	Brand Name (Non-Formulary): \$10 0		

- *If the member chooses brand when a generic is available, member pays the cost difference between the brand name and the generic drug PLUS the genenic copayment.
- (1) These services require Pre-Certification by Encompass. Call 1-800-373-3727.
- (2) After 10 therapy visits, Pre-Certification by Encompass is required. Call 1-800-373-3727. All speech and occupational therapy visits have a \$20 copayment (therapy only) per visit. Copayment does not apply toward Deductible or Out-of-Pocket Limit. Maximum of 60 visits annually for speech therapy. Maximum of 60 visits annually for occupational therapy.
- (3) These services require Pre-Certification by Encompass after the first (7) seven sessions from one or more providers every year.
- (4) These services must be performed at recognized Blue Cross and Blue Shield (BCBS) "Center of Distinction" networks.

Important Note: Davis Vision Plan administers the vision benefits pursuant to plan guidelines.

This is a summary of material modifications. The terms of the plan document and any subsequent summary material modifications control.

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DAVIS VISION CARE BENEFITS FOR 2011 PPO MEDICAL PLAN

1-800-999-5431 • www.davisvision.com

Plan Benefit		Member Pays
IN-NETWORK	Once every:	
Eye Exam	12 months	\$0
Frame	12 months	—
Exclusive collection of frames	TE MONINO	\$0
\$50 In-network allowance, (in lieu of purcha	sina	Balance over \$50
from exclusive collection of frames)		
Lenses	12 months	
Standard		
Plastic or glass single vision,		\$0
bifocal, or multifocal types, in		\$0
any prescription		\$0
Oversized lenses		\$0
Polycarbonate lenses *		\$0
Glass gray #3 prescription lenses		\$0
Contact lenses	12 months	\$0
Plan contact lenses		\$0
In-Network Allowance for non-plan contac	:S	Balance over \$105
Optional		
Ultraviolet coating		\$0
Scratch resistant coating		\$18
Standard anti-reflective coating ARC		\$31
Premium anti-reflective coating		\$43
Ultra anti-reflective coating		\$60
Fashion and gradient tinting of plastic lens	 es	\$0
Polycarbonate lenses (Adult)		\$27
Blended segment lenses		\$0
Corning Photochromic Lenses		\$0
Intermediate Vision Lenses		\$25
High Index Plastic Lenses		\$50
Plastic Photosensitive Lenses		\$59
Polarized Lenses		\$68
	-	
Standard progressive addition lenses (PAL	s)	\$45
Premium Progressive Additional Lenses		\$80
OUT-OF-NETWORK REIMBURSEMENT SCHEDULE	Once every:	
	12 months	Balance over \$35
Eye exam		Daiance over \$55
Lenses (per pair)	12 months	D-I #0F
Single		Balance over \$35
Bifocal		Balance over \$50
Trifocal		Balance over \$60
Lenticular		Balance over \$60
Frame	12 months	Balance over \$50
Contact Lenses (in lieu of glasses)	12 months	

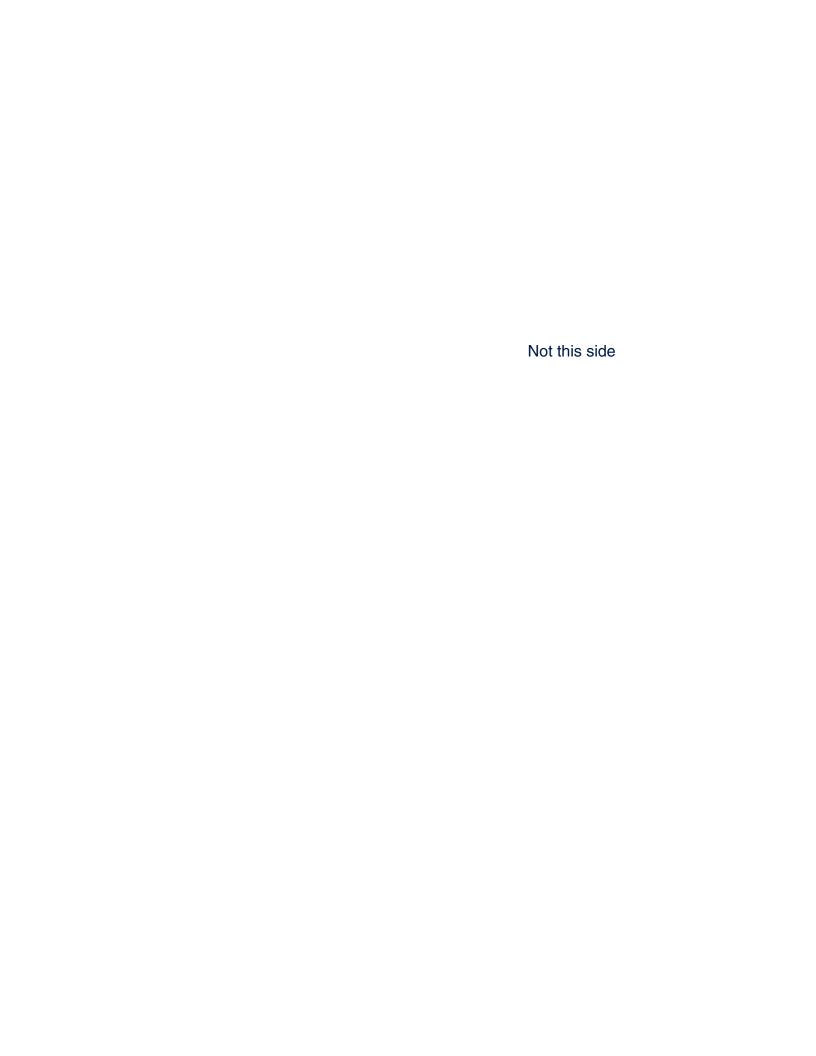
^{*}Polycarbonate lenses covered in full for dependent children, monocular patients and patients with prescriptions >= +/- 6.00 diopters

MEDICAL PLAN HMO BENEFITS FOR BLUE PERFORM AND BLUE ADVANTAGE

OUTPATIENT CARE IN THE HMO H	EALTH CENTER OR HMO PHYSICIAN'S OFFICE
Diagnostic Testing (i.e., x-ray, lab, etc.)	Covered in full
Surgery	Covered in full with \$20.00 co-payment per visit
Routine Physical Checkups (Adults)	Covered in full with \$20.00 co-payment per visit
Routine Pediatric Checkups, Well Baby	Covered in full with \$20.00 co-payment per visit
Care & Pre-school exams	
Immunizations	Covered in full
Allergy Shots	Covered in full
Hearing Screening	Covered in full
Physical Therapy, Occupational Therapy & Speech Therapy	Sixty (60) combined visits - per calendar year. Covered in full for conditions which, in the judgment of the attending or consulting physicians, are sufficient for significant improvement. These services are provided for restoration of functions only; services for the acquisition of function are not covered.
Podiatry Care	Covered in full with \$20.00 co-payment per visit. Routine foot care and prescriptions for supportive foot devices not covered.
Oral Surgery	Covered in full with \$20.00 co-payment per visit. Services for dental care are not covered unless required due to surgical removal of a tumor, in connection with an injury, or for treatment of malerupted bony impacted wisdom teeth.
INPATIENT CARE IN AN HMO-AFF	LIATED HOSPITAL
Hospital Services	Covered in full with \$20.00 co-payment per admission.
Number of Days	Unlimited
Intensive Care & Other Special Units	Covered
Doctor Visits	Covered
Specialist Visits	Covered with authorization from Primary Care Physician.
Anesthesiologist	Covered
Surgery	Covered
Prenatal & Postnatal	Covered in full with \$20.00 co-payment per initial visit.
Inpatient (semi-private room)	Covered (Private room covered in full if medically necessary)
MENTAL HEALTH AND SUBSTANC	F ABUSE TREATMENT
Mental Health Outpatient Visits	Covered in full with \$20.00 co-payment per visit.
Mental Health Inpatient Care	Covered in full with \$20.00 co-payment per admission.
Substance Abuse/Chemical Dependency Treatment - Outpatient Visits	Covered in full with \$20.00 co-payment per visit.
Substance Abuse/Chemical Dependency Dependency Treatment -Inpatient Care	Covered in full with \$20.00 co-payment per admission.
EMERGENCY CARE	
A medical emergency is the sudden and une tions are always severe, sudden in onset and	xpected onset of a potentially dangerous situation which, if not treated immediately, could jeopardize the patient's health. Such condi- involve one of the major organs of the body.
Provided in full at Primary Care Physician's day, seven days a week. In a life-threatening	office or emergency room. If possible, contact your Primary Care Physician first. Your Primary Care Physician is available 24 hours a emergency, call your Primary Care Physician within 48 hours following emergency treatment.
Emergency Room Treatment (Life Threatening)	\$100 Emergency room co-payment (Waived if patient is admitted)
Ambulance (Life Threatening)	Covered in full
Acute Medical Problems (Non-Life Threatening)	Covered in full. Doctors are on call 24 hours a day, seven days a week. Call the emergency number on your ID card or your Primary Care Physician. The physician or nurse will listen to your problem, instruct you to come in for care or direct you to a participating medical facility.
PRESCRIPTIONS	
Retail - 30-day supply	Generic: \$10.00 co-pay
(Short-term medication)	*Brand Name (Formulary): \$30.00 co-pay *Brand Name (Non-Formulary): \$45.00 co-pay (*If the member chooses brand when a generic is available, member pays the cost difference between the brand and the generic drug PLUS the generic co-pay) Important Note: Generic or brand name drugs not included on the formulary are not available through mail order.
Mail Order (Long-term medication for chronic conditions) 90 day supply	Member co-payments are two times the cost of retail co-payments. (If the member chooses brand when a generic is available, member pays the cost difference between the brand and the generic drug PLUS the generic co-pay). \$20.00 (Generic) \$60.00 (Formulary brand) Important Note: Non-formulary drugs are not available through mail order. If there is no generic or alternative brand name formulary medication on the primary/preferred drug list, you may be able to purchase your medications through the mail order program.
Oral Contraceptives (90 day supply)	Covered with co-payment
ADDITIONAL SERVICES	
Prosthetic Devices and Durable Medical Equipment (DME)	Covered in full
Blood	Covered in full
Infertility Treatment	Covered in full
Home Health Services	Covered in full
Skilled Nursing Facility	Covered in full, up to 120 days per calendar year.

[&]quot;Covered in full" means a service is covered to the full extent required by the City and its agreement with the HMO. In some instances, there may be limits on frequency of service. All services listed for the HMOs must be authorized in advance by Plan Physicians in order to be covered.

This HMO Benefit Highlight Sheet describes eligibility and benefits available for the 2011 plan year. It is only to be used as a guide. Please refer to specific benefit booklets available from the HMO for more detailed information.



MEDICAL HMO COMPARISON FOR 2011

Blue Perform HMO (A Blue Cross HMO) 1-800-730-8504 • www.bcbsil.com

Benefits Outside The Service Area: <u>Urgent Care</u> is covered while traveling out-of-state for unexpected illness and injury. When medical services are needed away from home, call our easy to remember toll-free number and we'll quickly put you in touch with an Away From Home Coordinator near your location. The Coordinator will schedule an appointment for you, give you directions and help take the fear out of being sick away from home.

<u>Guest Membership</u> is provided at an affiliated HMO if you or a covered dependent travels away from the service area for at least 90 days. Whether the reason is extended out-of-town business, semesters at school or families living apart, you can still enjoy the full range of benefits offered by the affiliated HMO near your travel destination.

Uniview Vision Care Benefits - You and your covered dependents are eligible to receive a routine eye examination once every 12 months for the cost of your office visit copayment. After you pay a \$20 copayment, lenses are covered at 100%. Frames are covered up to \$130. You pay a discounted cost over the \$130 limit.

Visit UniView Vision Member Access, www.unicare.com, where you can easily review your vision benefits, check your eligibility, search for a provider, and manage dependent information. For customer service assistance call 1-888-884-8428.

Blue Advantage HMO (A Blue Cross HMO) 1-800-730-8504 • www.bcbsil.com

Benefits Outside The Service Area: <u>Urgent Care</u> is covered while traveling out-of-state for unexpected illness and injury. When medical services are needed away from home, call our easy to remember toll-free number and we'll quickly put you in touch with an Away From Home Coordinator near your location. The Coordinator will schedule an appointment for you, give you directions and help take the fear out of being sick away from home.

<u>Guest Membership</u> is provided at an affiliated HMO if you or a covered dependent travels away from the service area for at least 90 days. Whether the reason is extended out-of-town business, semesters at school or families living apart, you can still enjoy the full range of benefits offered by the affiliated HMO near your travel destination.

Davis Vision Care Benefits: You and your covered dependents are eligible to receive an eye examination and contact lens evaluation, fitting and follow-up once every 12 months for the cost of your office visit copayment. Your benefits include a \$150 allowance, plus discounts off retail cost, toward the purchase of eyeglasses (frames and standard spectacle lenses) and/or contact lenses, once every 12 months.

Call Davis Vision customer service at 1-877-393-8844, to locate a network provider or for further information. For more information on discounts on laser vision correction surgery and disposable contact lenses, call TLC/TruVision customer service at 1-866-484-2020.



RICHARD M. DALEY, MAYOR

CITY OF CHICAGO



DENTAL PLAN COMPARISON FOR 2011

compbenefits dental www.compbenefits.com/custom/cityofchicago 1-800-837-2341	DENTAL HMO PLAN	DENTAL PPO PLAN		
BENEFIT DESIGN	MUST USE PANEL DENTISTS	IN-NETWORK	OUT-OF-NETWORK	
Individual Deductible	\$0	\$100 per person, per year effective 1/1/06	\$200 per person, per year effective 1/1/06	
Annual Maximum Benefit	Unlimited	\$1,200 per person, effective 1/1/02	\$1,200 per person, effective 1/1/02	
ORTHODONTIC PROCEDURES (Braces)	Co-payment (Member pays)			
Sworn Police and Uniformed Firefighters (Under Age 25 only) All Others (Under Age 19 only)	Effective 1/1/06 \$2,300	Not Covered		
PREVENTIVE SERVICES				
Oral Exams (twice a year) Cleanings (twice a year) X-Rays (twice a year) Space Maintainers (children under 12)	100% Covered in full (no deductible) \$10 Co-payment required for each preventive service office visit.	100% Covered in full (no deductible) \$10 Co-payment required for each preventive service office visit.	Plan pays 80% of PPO allowable amount (no deductible). Member pays balance of billed charges.	
BASIC PROCEDURES	Co-payments (Member pays) Effective 1/1/07	Deductible Applies		
Amalgam (Fillings) - one surface permanent	\$20			
Resin - one surface anterior including acid etch-	\$24			
Pin Retention (per tooth) - in addition to restoration	\$31			
Routine Extraction Single Tooth	\$24			
Surgical Removal of Erupted Tooth	\$45	_		
Surgical Removal of Tooth - soft tissue impaction	\$58	_		
Surgical Removal of Tooth - partial bony impaction	\$83	_		
Surgical Removal of Tooth - complete bony impaction	\$83	_		
Alveoloplasty - without extractions - per quadrant	\$96	_		
Scaling and Root Planing - per quadrant with local anesthesia	\$45			
Gingivectomy or Gingivoplasty - per quadrant	\$183	7		
Gingival Flap Procedure Including	* **	┪		
Root Planing - per quadrant	\$175	Plan pays 60%	Plan pays 50%	
Osseous Surgery, Flap Entry and Closure - per quadrant	\$203	of PPO allowable amount.	of PPO allowable amount.	
Pulp Capping (direct or indirect)	\$15	Member pays 40%	Member pays	
Root Canal Therapy	0.10	of PPO allowable amount.	balance of billed charges.	
anterior	\$149 \$160			
bicuspid molar	\$160 \$215			
Apicoectomy - (first root)	\$138	┥		
Palliative Treatment	\$17	┦		
Limited Occlusion Adjustment	\$26	7		
MAJOR RESTORATIVE PROCEDURES				
Inlay - metallic (one surface)	\$276	7		
Onlay - metallic (three surfaces)	\$373	7		
Core Buildup Including Pins	\$110	7		
Crown repair	\$85	7		
Crown - porcelain/ceramic substrate	\$385	7		
Crown - fused to high nobel metal	\$395	7		
Denture - complete upper or lower	\$485			
Lower Denture Reline - chairside	\$147	7		

To obtain a current list of dentists in either the HMO or PPO plan, please contact CompBenefits. The website and customer service phone number are listed at the top of this chart. Important Note: This comparison provides only the highlights of the programs. Specific details are contained in the plan document booklet. If conflict arises between this material and any plan provisions, the terms of the actual Plan documents or other applicable documents will govern in all cases.

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RICHARD M. DALEY, MAYOR

CITY OF CHICAGO



2011 IMPORTANT WEB SITES AND TELEPHONE NUMBERS				
Plan Eligibility and Benefit Coverage	City of Chicago Benefits Management Office	www.cityofchicago.org/benefits	1-312-747-8660	333 S. State Street, Room 400 Chicago, IL 60604-3978
Medical Plans PPO Plan Blue Advantage HMO Blue Peform HMO	Blue Cross and Blue Shield of Illinois	www.bcbsil.com	1-800-772-6895 1-800-730-8504 1-800-730-8504	(For Claims Processing) 300 East Randolph Street Chicago, IL 60601–5099
Medical Plan Prescriptions Blue Advantage HMO Blue Peform HMO	Blue Cross and Blue Shield of Illinois	www.bcbsil.com	1-800-423-1973	(For Claims Processing) 300 East Randolph Street Chicago, IL 60601-5099
PPO Plan	CVS Caremark	www.caremark.com	1-866-748-0028	(For Mail Order Prescriptions) P.O. Box 94467 Palatine, IL 60094-4467 (For Claims Processing) P.O. Box 686005 San Antonio, TX 78268-6005
Medical Plan Advisor PPO Plan	Encompass Health Management System	www.encompassonline.com	1-800-373-3727	1776 Westlakes Parkway West Des Moines, IA 50266-7771
Dental Plans Dental HMO & Dental PPO	CompBenefits	www.compbenefits.com/custom/cityofchicago	1-800-837-2341	200 W. Jackson Blvd., 9th Floor Chicago, IL 60606-6910 (For Claims Processing) P.O. Box 14282 Lexington, KY 40512-4282
Vision Care Benefits PPO Plan Blue Advantage HMO	Davis Vision	www.davisvision.com	1-800-999-5431 1-877-393-8844	159 Express Street Plainview, NY 11803-9526
Blue Peform HMO	UniView	www.unicare.com	1-888-884-8428	P.O. Box 8504 Mason, OH 45040-7111
Flexible Spending Account	PayFlex (FSA)	www.HealthHub.com	1-800-284-4885	Flex Dept PO Box 3039 Omaha, NE 68103-3039
Life Insurance Plans Term Life Insurance	Prudential Insurance Company of America	www.prudential.com	1-800-778-3827	PO Box 13676 Philadelphia, PA 19176 Attn: Greta Gibbs
Universal Life Insurance	MetLife Underwritten by TexasLife	www.empben/CityofChicagoUL.com	1-800-638-6855	2650 Warrenville Rd, Suite 100 Downers Grove, IL 60515 Attn: Debbie Forsythe
Long Term Disability	Standard Insurance (LTD)	N/A	1-800-535-8465	900 SW Fifth Avenue Portland, OR 97204-1282
Deferred Compensation	Nationwide Retirement Solutions	www.chicagodeferredcomp.com	1-312-443-1975 1-877-677-3678	205 W. Randolph Street, Suite 1540 Chicago, IL 60606-1814
Transit Benefit	Wageworks	www.wageworks.com	1-877-924-3967	1100 Park Place San Mateo, CA 94403
Pension Funds Uniformed Firefighters	Firemen's Annuity and Benefit Fund of Chicago	www.fabf.org	1-312-726-5823	20 South Clark Street, Room 1400 Chicago, IL 60603
Sworn Police	Policemen's Annuity and Benefit Fund of Chicago	www.chipabf.org	1-312-744-3891	221 N. LaSalle Street, 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	221 N. LaSalle Street, Suite 500 Chicago, IL 60601-1294
Laborer Employees	Laborers and Retirement Board Employee Annuity Benefit Fund of Chicago	www.labfchicago.org	1-312-236-2065	221 N. LaSalle Street, Suite 748 Chicago, IL 60601-1206