# PLAN A-2 PPO
# SCHEDULE OF BENEFITS
## CITY OF CHICAGO EMPLOYEES

Effective April 1, 2023

All benefits are subject to eligibility, maximum Plan benefit, reasonable and customary determination (or negotiated fee amounts for PPO provider services), and any special limits noted in the Plan. Charges that exceed the reasonable and customary amount or the Plan limitations will not be eligible in determining Plan benefits.

Special rules apply to any benefits subject to the No Surprises Act. The No Surprises Act protects patients who receive emergency services at a hospital, at an independent freestanding emergency department and from air ambulances. In addition, the law protects patients who receive emergency services from an Out-of-Network provider at an In-Network facility. In certain circumstances, non-emergency items or services that are otherwise covered by the Plan from an Out-of-Network provider who is working at an In-Network facility are also subject to the No Surprises Act.

For benefits subject to the No Surprises Act, any cost-sharing payments count toward your In-Network deductible and In-Network Out-of-Pocket Expense Maximum. An explanation of your rights under the No Surprises Act is available at http://local150.org/wp-content/uploads/2022/04/NSA-Notice.pdf.

Eligible expenses must be medically necessary and are subject to the Plan Year deductible unless otherwise noted. Age limitations, as specified in this *Schedule of Benefits*, are applied as of the last day of the month in which the eligible dependent's birthday occurs.

**Please Note:** In accordance with a collective bargaining agreement between the City of Chicago and the Union, members who were previously covered under this Plan but who would otherwise have lost such coverage when they became employed by the City of Chicago are permitted to make quarterly flat-rate contributions to the Fund for supplemental health benefits. The amount of the required quarterly contribution is determined by the Trustees. To be eligible for benefits from this Fund, the member must be employed by the City of Chicago and must elect and be eligible for health care benefits through the City of Chicago.

| **Member Eligibility** | |
|---|---|
| **Initial Eligibility** | The first day of the Benefit Quarter for which you make the required contribution to the Fund. "Benefit Quarter" is a period of three consecutive months beginning January 1, April 1, July 1, and October 1. |
| **Continuing Eligibility** | Eligibility will continue as long as you make the required contribution to the Fund and maintain your group coverage through the City of Chicago. |
| **Termination of Eligibility** | Eligibility will terminate upon the earliest of the following dates:<br>• At the end of the last day of the Benefit Quarter for which you made the required contribution to the Plan;<br>• At the end of the Benefit Quarter preceding the Benefit Quarter for which you first fail to maintain your group coverage through the City of Chicago; or<br>• The date of your death. |
| **Reinstatement** | If your eligibility terminates, it cannot be reinstated. |

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| Dependent Eligibility | | |
|---|---|---|
| **Initial Eligibility** | A dependent who meets the definition of an eligible dependent will become eligible on the date your eligibility is effective or on the date you acquire and enroll the eligible dependent, whichever is later. | |
| **Termination of Eligibility** | Dependent eligibility will terminate upon the earliest of the following dates:<br>• The end of the Benefit Quarter in which the dependent stops meeting the definition of an eligible dependent;<br>• The date your coverage terminates, except that in the event of your death, the dependent's eligibility will terminate on the last day of the Benefit Quarter for which you had satisfied the continuing eligibility requirements; or<br>• The date of the dependent's death. | |
| **Operators' Health Center (Ages two and up)/Everside Health Centers (Ages vary at each location)** | | |
| **Annual physical exam, preventive care/wellness visits, immunizations, blood draws, condition management, DOT physicals, physical therapy (physical therapy is available at both Operators' Health Centers), and behavioral health (available at the Countryside, IL Operators' Health Center via in-person or telehealth; limited behavioral health at the remaining health centers), chiropractor services at Everside Health Centers (Rockford, IL and Davenport, IA)**<br>Not subject to the deductible | 100% | |
| **CVS Minute Clinics** | | |
| **Non-Emergency, Unscheduled Acute Illness, or Injuries**<br>Additional "cash pay" services are available at a cost to the patient<br>Not subject to the deductible | Most services covered at 100% | |
| **Medical & Prescription Drug Benefit Combined Out-of-Pocket Expense Maximum** | **In-Network** | **Out-of-Network** |
| The amount of money applied toward the medical and pharmacy out-of-pocket maximum; it includes medical deductible and pharmacy copayments; it does not include coinsurance for orthoptic training or temporomandibular joint disease (TMJ) treatment | $4,500 per individual<br>$10,000 per family | $6,500 per individual<br>$14,000 per family |
| **Medical Benefit (Comprehensive Medical Benefit)** | **In-Network** | **Out-of-Network** |
| **Annual Maximum**<br>Per Plan Year | Unlimited | |
| **Individual Deductible**<br>Per person, per Plan Year<br>All benefits are subject to the deductible unless otherwise noted<br>The three-month carryover applies<br>In-network and out-of-network deductibles are separate and will not cross apply | $300 | $300 |

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| Medical Benefit<br>(Comprehensive Medical Benefit) | In-Network | Out-of-Network |
|---|---|---|
| **Family Deductible**<br>Per Plan Year<br>The three-month carryover does not apply<br>In-network and out-of-network deductibles are separate and will not cross apply | $700 | $700 |
| **Out-of-Pocket Expense Limitation**<br>The most an individual could pay in a Plan Year for covered services, including the deductible. Individuals covered under Family coverage must meet their own individual out-of-pocket expense limit until the overall Family out-of-pocket expense limit has been met<br>Does not include premiums, balance-billing charges, Family Supplemental Benefits, TMJ, orthoptic training, dental benefits, and health care not covered by the Plan | $2,500 per individual<br>$6,000 per family | $2,500 per individual<br>$6,000 per family |
| **PPO Networks** | BlueCross BlueShield PPO,<br>Absolute Solutions, ATI, Gateway, Recovery Centers of America (RCA) | Not applicable |
| **Inpatient Hospital Services**<br>Room allowances based on the hospital's most common semi-private room rate<br>Pre-admission testing is covered once prior to surgery<br>Requires approval by the Case Manager | 90% | 80% |
| **Skilled Nursing Facility**<br>If recommended by a physician and confinement begins within 30 days of a hospital confinement<br>Follow Medicare guidelines for breaks in skilled nursing facility care<br>Maximum per disability: 45 days<br>Requires approval by the Case Manager | 90% | 80% |
| **Home Health Care**<br>If ordered by a physician<br>Requires approval by the Case Manager | 90% | 80% |
| **Outpatient Hospital Services**<br>Including licensed surgery centers<br>Outpatient surgical procedures not performed in the doctor's office requires approval by the Case Manager | 90% | 80% |
| **Emergency Services in a Hospital or Independent Freestanding Emergency Department**<br>Facility charges | 90% | 90% |
| **Diagnostic X-rays/Lab**<br>X-rays and/or tests to diagnose a condition or to determine the progress of an illness or injury | 90% | 80% |
| **MRI/CT and PET Scans** | 100%, not subject to the deductible if scheduled through Absolute Solutions; otherwise, 90% | 80% |
| **Outpatient Physical and Occupational Therapy**<br>Must be performed by a licensed provider<br>Requires approval by the Case Manager | 100%, not subject to the deductible if received at an ATI Physical Therapy Facility; otherwise, 90% | 80% |

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| Medical Benefit<br>(Comprehensive Medical Benefit) | In-Network | Out-of-Network |
|---|---|---|
| **Outpatient Restorative Speech Therapy (Children and Adults)**<br>Must be performed by a licensed provider<br>Requires approval by the Case Manager | 90% | 80% |
| **Outpatient Speech Therapy for Developmental Condition, including Congenital Neurological Diseases for individuals ages two through 18**<br>Must be performed by a licensed provider<br>Requires approval by the Case Manager | 90% | 80% |
| **Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for individuals through age 18 only**<br>Must be performed by a licensed provider<br>Requires approval by the Case Manager | 100%, not subject to the deductible if received at an ATI Physical Therapy Facility; otherwise, 90% | 80% |
| **Orthoptic Training**<br>For dependent children up to age 10 only<br>Training needs to be prescribed by a covered provider<br>Lifetime maximum: 40 visits<br>Not subject to the deductible or out-of-pocket maximums<br>Does not count toward the medical & prescription drug benefit combined out-of-pocket expense maximum or the medical benefit out-of-pocket expense limitation; if you reach an out-of-pocket maximum, you will continue to pay 50% coinsurance for orthoptic training services; the Plan will not pay 100% for orthoptic training services after you reach a benefit out-of-pocket maximum<br>Requires approval by the Case Manager | 50% | |
| **Physician's Medical/Surgical Care**<br>Office visits, hospital visits, surgery, assistant surgeon, etc.<br>Certain procedures performed in the physician's office may require approval by the Case Manager | 90% | 80% |
| **Preventive Care, including Well Woman and Well Child Care**<br>Includes routine physical exams, routine labs, routine outpatient visits and immunizations<br>Refer to https://www.healthcare.gov/coverage/preventive-care-benefits/ for more information and the list of current ACA-required preventive services | 100% subject to ACA guidelines, deductible does not apply | Not covered, except in certain situations |
| **Chiropractic Services**<br>Limit of $60 per visit and 24 visits per Plan Year | 100%, not subject to the deductible if received at an Everside Health Center; otherwise, 90% | 80% |

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| Medical Benefit (Comprehensive Medical Benefit) | In-Network | Out-of-Network |
|---|---|---|
| **Durable Medical Equipment**<br>Rental paid up to purchase price of the equipment, except for lifetime items that do not have a purchase price<br>Includes necessary adjustments or repairs, or replacement, if more cost effective<br>Electric wheelchair limited to $15,000<br>Not subject to the deductible<br>Requires approval by the Case Manager on equipment over $1,000 | 80% | 80% |
| **Foot Orthotics**<br>Custom-fitted foot orthotics prescribed by a physician<br>Plan Year maximum: $300<br>Lifetime maximum: $1,500 | 80% | 80% |
| **Prosthetic Devices**<br>Artificial devices to restore a normal body function<br>Requires approval by the Case Manager | 80% | 80% |
| **Transplants**<br>Available to all non-Medicare-eligible members and dependents<br>*If Medicare is primary, Medicare-eligible members and dependents must use Medicare-approved providers*<br>Benefit begins five days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure<br>Transportation and lodging maximum: $10,000<br>Private duty nursing maximum: $10,000<br>Requires approval by the Case Manager | 90% | Not covered |
| **Orthodontic Treatment of Temporomandibular Joint Disease (TMJ)**<br>Not subject to the deductible or out-of-pocket maximums<br>Does not count toward the medical & prescription drug benefit combined out-of-pocket expense maximum or the medical benefit out-of-pocket expense limitation; if you reach an out-of-pocket maximum, you will continue to pay 50% coinsurance for TMJ services; the Plan will not pay 100% for TMJ services after you reach a benefit out-of-pocket maximum<br>Lifetime maximum: $2,500<br>Requires approval by the Case Manager | 50% | |
| **Cochlear Implants**<br>Requires approval by the Case Manager | 90% | Not covered |
| **Medical Transportation**<br>Includes ground and air transport from the site of the injury, medical emergency, or acute illness to the nearest facility<br>Includes ground non-emergency transfer from hospital to home hospice care if home is less than 100 miles from hospital<br>Inter-health-care-facility transfer maximum: $5,000 | 90% | |

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| Medical Benefit (Comprehensive Medical Benefit) | In-Network | Out-of-Network |
|---|---|---|
| **Acupuncture**<br>Services performed by a licensed provider within the scope of his or her license<br>Maximum of 12 treatments per Plan Year<br>Up to $125 allowable per visit | 90% | 80% |
| **Sleep Apnea Appliance**<br>When ordered by a physician and provided by a medical equipment supplier or dentist<br>Appliance replacement once every five years if existing appliance is covered<br>Requires approval by the Case Manager | 90% | 80% |
| **Mental Illness and Substance Abuse (Subject to the medical deductible)** | **In-Network** | **Out-of-Network** |
| **Mental Health and Substance Abuse Network** | BlueCross BlueShield PPO, Gateway, RCA | Not applicable |
| **Inpatient Care**<br>Requires approval by the Case Manager | 100%, not subject to the deductible if received at Gateway/RCA Facility; otherwise, 90% | 80% |
| **Outpatient Care**<br>ABA Therapy, IOP and PHP requires approval by the Case Manager | 100%, not subject to the deductible if received at Gateway/RCA Facility; otherwise, 90% | 80% |
| **Residential Facility**<br>Requires approval by the Case Manager | 100%, not subject to the deductible if received at Gateway/RCA Facility; otherwise, 90% | 80% |
| **Member Assistance Program (MAP)**<br>Administered by Employee Resource System (ERS) | Provides members and covered dependents with up to five no-cost visits per episode per Plan Year<br>Additional counseling or treatment may require payment | |
| **Dental Benefit** | **In-Network** | **Out-of-Network** |
| **Dental PPO Network and Claims Administration** | Delta Dental PPO | Not applicable<br>If you use a non-network dentist, Delta Dental will pay you directly, leaving you responsible to pay the provider |
| **Deductible** | $0 | |
| **Plan Year Maximum**<br>No maximum for children under age 19 | $1,500 per adult (age 19 and older) | |
| **Preventive** | 100% | |
| **Basic and Major Services**<br>Fillings, crowns, root canal therapy, oral surgery, dentures, bridgework, and other covered dental services | 70% coinsurance is based on Delta Dental's Allowable Fee<br>You pay the full cost of services above the Allowable Fee if you use an Out-of-Network provider | |
| **Orthodontia**<br>Dependent children through age 18 only<br>Lifetime maximum: $2,000 | 50% coinsurance is based on Delta Dental's Allowable Fee<br>You pay the full cost of services above the Allowable Fee if you use an Out-of-Network provider | |

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| | |
|---|---|
| **Disability Benefit** | |
| Available to members only | $400 per week for the first 30 days of disability<br>(prorated for any paid days off) |
| **Death Benefit** | |
| Available to members and eligible dependents | $7,500 per eligible member<br>$2,000 per eligible dependent |
| **Accidental Dismemberment Benefit** | |
| Available to members only | $1,000 or $5,000 based on type of loss<br>Limited to $10,000 for any one accident |
| **Family Supplemental Benefit** | |
| This benefit can be used for non-covered medically necessary and un-reimbursed medical, dental and pharmacy benefit expenses, including items such as hearing aids, glasses, etc. It cannot be used to reimburse expenses covered under the prescription drug program<br>Reimbursement for Plan maximums and items covered at 50% that are not subject to the out-of-pocket maximum are eligible<br>Other than stated above, this benefit cannot be used to reimburse the deductible, copayment, or amount over the reasonable and customary amount | Maximum per family, per Plan Year: $1,500 |

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**Prescription Drug Program**

Prescription drug benefits will be paid for prescriptions on the OptumRx Select Formulary when filled at a pharmacy in the Pharmacy Benefit Manager's (PBM's) network

Long-term medications (Maintenance drugs) must be filled at a CVS retail pharmacy or through the OptumRx Home Delivery Pharmacy

Medical deductible does not apply for prescription drugs

No coordination of benefits applies

Specialty medications must be filled through the Optum Specialty Pharmacy; specialty medications are limited to a 30-day fill

No coverage for out-of-network pharmacies until you reach your out-of-pocket maximum as noted below; once the out-of-pocket maximum is met, prescriptions will be paid at 100%

Medication used to treat Cancer and transplant medications billed by OptumRx are subject to the following 4-tier structure

| | In-Network | | Out-of-Network |
|---|---|---|---|
| | **OptumRx Network Retail Pharmacy (up to two 30-day fills)** | **CVS retail pharmacy or OptumRx Home Delivery (up to a 90-day fill)** | |
| **Generic Drug (Tier 1)** | $5 copayment(1) for a 30-day supply | $15 copayment(1) for a 90-day supply | Not covered |
| **Preferred Brand Name Drug (Tier 2)** | $10 copayment(1) for a 30-day supply | $30 copayment(1) for a 90-day supply | Not covered |
| **Non-Preferred Brand Name Drug (Tier 3)** | $25 copayment(1) for a 30-day supply | $45 copayment(1) for a 90-day supply | Not covered |
| **Specialty Drug (Tier 4)** Requires authorization | $100 copayment(1) for a 30-day supply | Not applicable | Not covered |
| **Pharmacy Out-of-Pocket Maximum** | $2,000 per individual<br>$4,000 per family | | $4,000 per individual<br>$8,000 per family |
| **Compounded Drugs (A minimum of one ingredient must be covered under the prescription drug program)** | Prescriptions exceeding $300 require authorization | | Not covered |
| **Convalescent or Nursing Home** | Follows the above copayment structure | | 50% of the cost of the medication |

(1) Copayments listed are the Plan's basic copayment schedule; if the cost of the medication is less than the copayment listed, you will be responsible for paying the lower cost.

**Limitations & Exceptions**

Maximum of up to two 30-day supplies of the same medication, can be filled at any local in-network pharmacy before you are required to obtain a 90-day supply. If you are seeking a third refill, you must transition to a CVS retail pharmacy or the OptumRx Home Delivery Pharmacy or pay 100% of the cost of the prescription drug. Please call OptumRx at (855) 697-9150 or visit www.optumrx.com for more information.

*When available, generic drugs will be substituted for all brand name drugs or medications. If you request a brand name drug, or if the prescribing physician indicates "no substitutions," when a generic equivalent is available, you will be required to pay the brand name drug copayment plus the difference in cost between the brand name drug and its generic equivalent unless determined medically necessary through the appeals process.*

*For a list of no-cost preventive medications, visit **https://local150.org/moe/prescription-drug-program/prescription-benefit-active-members-and-non-medicare-retirees/**.*