City of Chicago
Rahm Emanuel
Mayor

Department of Finance
Benefits Management Division
www.cityofchicago.org/benefits

Open Enrollment For 2015

Important Information Guide

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); Supervising Police Communications Operators represented by Teamsters Local 700; Aviation Security Sergeants represented by the Illinois Council of Police; Public Health Nurse III's and IV's represented by Teamsters Local 743 and Uniformed Firefighters and Paramedics represented by the Chicago Fire Fighters Union, Local No. 2.

City of Chicago Benefits Service Center and Website

Phone: 1-877-299-5111

Toll Free / 8am - 5pm / M-F

Online Plan Changes and FSA Re-Enrollment
www.cityofchicagobenefits.org

24Hrs / 7 days a week

The City of Chicago will hold the next Medical/Dental & Flexible Spending Account (FSA) Open Enrollment for all eligible employees from Monday, Nov. 3rd through Tuesday, Nov. 18, 2014. During this enrollment, you will have the chance to:

- Change your medical and/or dental plan
- Enroll for coverage, if you don't have coverage now
- **Enroll your eligible dependents for coverage (up to their 26th birthday), if they aren't covered now**
- Cancel coverage for yourself or your dependents
- Combine coverage if you and your spouse are both eligible City of Chicago employees and enrolled in the same medical plan
- Re-enroll online in the FSA health plan or enroll for the first time. Open Enrollment and Re-enrollment website for FSA: **www.cityofchicagobenefits.org**

Contents Of Your Open Enrollment For 2015 Personalized Envelope:

This envelope contains the following communication materials to help you make the best plan enrollment choices and eligible dependent coverage decisions for next year:

- Your personalized cover letter
- Letter Regarding Chicago Labor-Management Trust
- Open Enrollment For 2015 Important Information Guide (this document)
- Medical and Dental Summary Guide for 2015
- Summary of Benefits and Coverage (SBC) cover letter
- SBC for Blue Choice OPT PPO Plan A
- SBC for Blue Advantage HMO Plan A
- PayFlex HealthCare FSA Flyer
- PayFlex Dependent Care FSA Flyer
- Prudential Website Enrollment Flyer
- Advanced Control Formulary

Here's What You Need To Know And Do Now:

Read Your Cover Letter

Enclosed in this envelope is a personalized Open Enrollment cover letter that provides the status of your current medical and dental coverage. It also lists eligibility information regarding your covered dependents.

Do You Want To Enroll Yourself Or Cancel Your Coverage For Next Year?

- If you are not currently enrolled in a City of Chicago medical plan and you wish to enroll at this time, or you are currently enrolled and you wish to cancel your coverage, you must go to: www.cityofchicagobenefits.org before 11:59 pm on November 18, 2014 or call 1-877-299-5111 before 5 pm.

Do You Want To Change Your Medical And/Or Dental Plan For Next Year?

- If your answer is yes, please visit: www.cityofchicagobenefits.org You can also call the City of Chicago Benefits Service Center at 1-877-299-5111.
- If your answer is no, then you will remain in the same medical plan for 2015.

Do You Want To Add/Delete An Eligible Dependent For Next Year?

If you are adding or deleting a spouse, civil union spouse, domestic partner or child dependent you must:

- First go to: www.cityofchicagobenefits.org before 11:59 pm on November 18, 2014 or call 1-877-299-5111 before 5 pm.
- Second, if you are *adding* any of the above dependents you must submit documents to prove dependency. Read the box to the right.

Social Security Numbers Are Required

Look at your cover letter to see if it says "Y" or "N" for your family's social security numbers. Federal law requires social security numbers for all persons covered by City health plans, including your dependents. If any social security number is marked "N", please call 1-877-299-5111 to update your dependent's records.

IMPORTANT NOTICE REGARDING PROOF OF DEPENDENCY REQUIREMENT

If you are adding or deleting anyone other than yourself, the process is not complete unless you provide satisfactory proof of dependency certified documents (i.e. certified marriage license, birth certificate etc).

To submit certified proof of dependency documents you must bring them or mail them to the following address by February 27, 2015:

City of Chicago / Department of Finance
Benefits Management Division
333 South State Street / Room 400
Chicago, IL 60604-3978

Enrollment for the person you are trying to add will not be complete if you fail to submit satisfactory proof of dependency certified documentation within the required time frame.

OPEN ENROLLMENT FOR 2015

BENEFITS SERVICE CENTER IS HERE TO ASSIST YOU

The City of Chicago Benefits Service Center continues to provide telephone customer service assistance for all eligible City of Chicago employees and their covered dependents for benefit questions or concerns. Your personalized benefit information is also available to you 24 hours a day via the internet at www.cityofchicagobenefits.org.

The full-service website allows you to do the following:

- Make annual enrollment elections for 2015.
- Review your current benefit elections.
- Verify personal information, such as address or dependent information.
- Make changes to your benefit elections because of a life event such as marriage, civil union, birth or adoption of a child, or divorce, etc.
- Access online enrollment and reinstatement options.

Enroll in City of Chicago Benefits

November 3 - 18, 2014, go to:

www.cityofchicagobenefits.org

from any computer or cell phone with Internet access or even from your local library.

If you do not have access to a computer, you can call the City of Chicago Benefits Service Center.

PHONE: 1-877-299-5111

TOLL FREE / 8AM - 5PM / M-F

Important Note: Certified documents and other required proof of dependency information must be submitted to the Benefits Management Office / 333 S. State Street / Room 400 / Chicago, IL 60604-3978. Office Hours: 8:30 am - 4:30 pm.

How Do I Re-Enroll or Enroll in the FSA Plan For 2014? During this Open Enrollment Period you must use www.cityofchicagobenefits.org Nov 3 through Nov 18, 2014 or by calling 1-877-299-5111.

IMPORTANT CHANGES TO YOUR PLANS

Key PPO points:

Within the PPO you can now choose to help control healthcare costs by selecting doctors and hospitals who have negotiated greater discounts with Blue Cross Blue Shield. The plan shares these discounts with you. This saves you money.

- You don't need to decide on a medical provider now. You can decide during the year when you need medical services.
- You can make a Blue Choice OPT selection sometimes and select a provider in the broader PPO network at other times.
- Different family members can make different choices.

Other 2015 Plan changes include:

- PPO prescription drug coverage is changing to the Advanced Control Formulary.
- Emergency room co-pay is increasing from $100 to $150 in both PPO and HMO plans.
- HMO office visit co-payments are increasing to $25 for primary care doctors and $35 for specialists.
- Sleep studies now require pre-approval by Telligen.

PPO PLAN OPTIONS – NEW IN 2015

The City is now offering a way to reduce healthcare costs and save you money in the PPO plan by allowing you to benefit from greater discounts that Blue Cross Blue Shield (BCBS) has negotiated with doctors and hospitals. Those doctors and hospitals are part of a new network available to PPO members called the Blue Choice OPT network. This is a new option to PPO members and using these providers is not mandatory. Choosing the PPO plan preserves your opportunity any time during the year to visit a doctor or hospital in the broader PPO network, or for greater savings, in the Blue Choice OPT network. This means that there are now three coverage levels (called "tiers").

One Plan, Three Tiers

Tier 1:	Blue Choice OPT network
Tier 2:	PPO network (the current network)
Tier 3:	Out of network

Tier 1: The Blue Choice OPT network

If you choose a provider or facility in the Blue Choice OPT network (Tier 1), your benefits will be as follows:

- ✓ Lower co-pays for doctor office visits ($20/$30)
- ✓ Lower deductibles ($300 individual/$900 family)
- ✓ Lower out of pocket limits ($1000 individual/$2000 family)
- ✓ Co-Insurance at 10% - *same as the 2014 PPO*

Tier 2: The PPO network

If you choose a provider or facility in the broad PPO network (Tier 2), your benefits will be as follows:

- ✓ Office visits co-pays ($25/$35) - *same as the 2014 PPO*
- ✓ Deductibles ($350 individual/$1050 family) - *same as the 2014 PPO*
- ✓ Out of pocket limit ($1500 individual/$3000 family) - *same as the 2014 PPO*
- ✓ Co-Insurance at 25%

Tier 3: Out of network

If you use an out of network provider, your benefits will be as follows:

- ✓ Preventive care is not covered
- ✓ Deductibles ($1500 individual/$3000 family) - *same as the 2014 plan*
- ✓ Out of pocket limit ($3500 individual/$7000 family) - *same as the 2014 plan*
- ✓ Co-Insurance at 40% - *same as the 2014 plan*

The Blue Choice OPT network (Tier 1) and the broad PPO network (Tier 2), when combined, include all of the current BCBS PPO hospitals and doctors that you have access to today. Both the Blue Choice OPT network (Tier 1) and the PPO network (Tier 2) are "in-network" providers that have agreed to accept the payments negotiated by BCBS of Illinois as payment in full. Neither Tier 1 nor Tier 2 providers will balance bill patients for amounts over the negotiated rates.

Out of network (Tier 3) providers are providers who are not participating in either the Blue Choice OPT network or the PPO network. This is the same as it is today. Cost sharing for these providers is unchanged, and patients will continue to be at risk for balance billing for all amounts that these providers charge above the amounts BCBS will pay.

FREQUENTLY ASKED QUESTIONS ON HOW THE NEW PLAN WILL WORK EFFECTIVE JANUARY 1, 2015

1. **How will the new tiered medical plan work?**

Each time you need medical care, you decide which provider to use. Your benefit (and out of pocket expense) will be different based on which medical providers you choose. You do not have to select a primary care doctor or choose a doctor in advance of when you need care. If you use providers who are in the Blue Choice OPT network (Tier 1), you will pay less than if you use providers in the broad PPO network (Tier 2). If you use providers who are not in either the Blue Choice OPT network (Tier 1) or the broad PPO network (Tier 2), you will pay more out of pocket because these providers are out of network providers (Tier 3). Out of network (Tier 3) providers can balance bill you for any amount not paid by the plan and the plan pays less for out of network care, as is the case today.

2. **What are the Blue Choice OPT network (Tier 1) and the PPO network (Tier 2)?**

The Blue Choice OPT network (Tier 1) is a subset of the PPO network you have today. If a current PPO provider is not a participant in the Blue Choice OPT network (Tier 1) they are a Tier 2 provider. As of now there are 10,358 primary care and 16,023 specialist doctors in the broad PPO network, of those 3,061 primary and 9,536 specialist doctors are also part of the Blue Choice OPT network. Ask your doctor if she or he participates in the Blue Choice OPT network.

3. **How do the deductibles work in the new plan?**

For the Blue Choice OPT network (Tier 1), the individual deductible is $300, which is $50 less than your current deductible. The PPO network (Tier 2) individual deductible is $350, the same as it is today. Any amount that you incur towards the Blue Choice OPT (Tier 1) individual deductible also helps meet your PPO (Tier 2) deductible. The reverse also applies--any amount that you incur towards the PPO (Tier 2) deductible applies towards the Blue Choice OPT (Tier 1) deductible. This means that for in-network services, you will pay no more than $350 towards a deductible--the same amount that you pay today. Once you have met your Tier level deductible, the plan starts to pay benefits at the level for the Tier your provider is in.

4. **Do the deductibles apply to doctors' office visits?**

In most cases, no. When you go to Tier 1 or Tier 2 doctor your co-payment will cover your cost for the visit. However, there are some doctors' office visits for which a separate hospital bill is also created. In those instances, the deductible and co-insurance will apply to the hospital bill.

For *preventive care visits*, there is **no co-pay** for Blue Choice OPT (Tier 1) and PPO (Tier 2) physicians. Preventive care is not covered out of network. If you would like to review the covered preventive care services, you can go to https://www.healthcare.gov/what-are-my-preventive-care-benefits/

5. **What happens if I need care when I go on vacation?**

Blue Cross Blue Shield of Illinois is part of a national network of providers that covers the United States--just as they are today. If you need care outside of Illinois and northwest Indiana, your care will be paid at the Tier 1 benefit level if you use providers who are part of the national Blue Card network.

6. **How are hospital expenses paid under the new plan?**

Hospital expenses are paid after you meet your deductible. For Blue Choice OPT network (Tier 1) providers, the deductible is $300 and the co-insurance amount is 10% until the out-of-pocket limit of $1000 is reached. For PPO network (Tier 2) hospitals, the deductible is $350 and the co-insurance is 25% until the out of pocket limit of $1500 is reached. As is true with the deductible, any co-insurance amount paid toward the Blue Choice OPT network (Tier 1) out of pocket limit also applies towards the satisfaction of the PPO network (Tier 2) co-insurance (and vice-versa). This means that for in-network services, the most you will pay for out of pocket expenses is $1500, the same amount as you pay today.

Other Benefits Changes

1. The emergency room co-pay is increasing from $100 to $150 in both the HMO and PPO plan. You do not have to pay the emergency room co-pay if you are admitted from the emergency room. You can also avoid the emergency room co-pay if you use a free standing clinic or physician's office or retail clinic.
2. Sleep studies must be pre-approved by Telligen in the PPO plan. You or your provider must call Telligen prior to any sleep study being performed. If a sleep study is performed without prior approval, the plan will not cover the expense of the sleep study.
3. Discounts for hospital claims in the PPO network will now be shared with members. Under the current plan, only the claims for doctor and other non-hospital (facility) providers are paid after the negotiated discounts have been deducted. Beginning in 2015, discounts will also be applied towards your hospital claims before your out of pocket expense is calculated. Your deductible and co-insurance amounts will be based on the reduced charges and not on the billed charges. This means that in many instances participants will pay less out of pocket because the discounts are applied before your deductible and co-insurance are calculated.

See examples on foldout →

Pharmacy Changes for 2015

New Formulary Beginning January 1, 2015: *The Advanced Control Formulary*

What is the New Advanced Control Formulary?

In 2015, the City of Chicago Employee Medical Plan PPO for LMCC members is switching to Caremark's ***Advanced Control Formulary***. This formulary promotes generics as the first line of prescribing and includes some brand-name drugs in many therapeutic classes. If there is no direct generic available, there may be more than one brand name medicine in the therapeutic class that can treat your condition.

Before January 1, 2015, you and your physician will receive information from Caremark if any of your current medications are not on the *Advanced Control Formulary***.** You and your doctor will be provided with the names of alternative medications for you to consider. The preferred brand name medicines will be listed in the guide which is published quarterly and available on line at **www.cvscaremark.com**. The *Advanced Control Formulary* list which is effective on January 1, 2015 is included with these materials. The preferred brand name medicines are listed to help identify alternative products that are clinically appropriate and cost-effective. If a preferred brand is medically appropriate for you, it may save you money. And if a generic is medically appropriate, it is usually your most cost effective alternative.

- Your prescription benefit plan design may not cover certain products or categories, regardless of their appearance in the Caremark Advanced Control Formulary document. Your plan design will control which drugs are covered. **Call Caremark at 1-866-748-0028 if you have a question about coverage of a specific drug.**
- You will be responsible for the full cost of products that are excluded from coverage. New prescription products may be subject to exclusion when they become available in the market.
- CVS/Caremark may contact your doctor after receiving your prescription to request consideration of a different drug. This may result in your doctor prescribing, when medically appropriate, a different brand-name product or generic equivalent in place of your original prescription.

Certain medications may no longer be covered. You and your doctor will receive letters from CVS/Caremark if any of your medications fall into this category. You will need to work with your doctor(s) to find an alternative. If you decide to continue with the medication, you will have to pay the full cost of the prescription at the City's negotiated discounted rate.

If there is a clinical reason why the preferred brand or generic options won't work for you, your doctor can call CVS/Caremark at 1-855-582-2026 to request information about the appeal process to allow you to continue to receive the current medication(s). If CVS/Caremark approves continued use of the current medication, you will be able to obtain the medication at the applicable non-formulary brand co-payment level.

The City will not handle appeals related to any clinical denials for prescription drug coverage for employees and dependents covered by the PPO; such appeals will be handled by CVS/Caremark. Also, if you are charged a non-formulary co-payment, no appeal is available as this does not constitute a denial of coverage.

Here are examples 1 and 2 that compare how claims are paid today with how claims will be paid starting January 1, 2015 when the three tier network and discount sharing are in place:

Example 1 Hospital in the Blue Choice OPT network (Tier 1)		
	2014	2015
discount shared	no	yes
Billed amount	$1,400.00	$ 1,400.00
PPO discount	$-	$812.00
Net Amount	$1,400.00	$588.00
Deductible (employee pays)	**$ 350.00**	**$300.00**
Amount remaining	$1,050.00	$288.00
co-insurance	10%	10%
co-insurance cost to employee	**$ 105.00**	**$28.80**
Employee total cost	**$ 455.00**	**$328.80**
Employee savings		**$126.20**

Example 2 Hospital in the broad PPO network (Tier 2)		
	2014	2015
discount shared	no	yes
Billed amount	$1,321.00	$ 1,321.00
PPO discount	$-	$841.48
Net Amount	$1,321.00	$479.52
Deductible (employee pays)	**$ 350.00**	**$350.00**
Amount remaining	$ 971.00	$129.52
co-insurance	10%	25%
co-insurance cost to employee	**$ 97.10**	**$32.38**
Employee total cost	**$ 447.10**	**$382.38**
Employee savings		**$64.72**

Here are examples 3 and 4 that compare how claims are paid today with how claims will be paid starting January 1, 2015 when the three tier network and discount sharing are in place:

Example 3 Hospital in the broad PPO network (Tier 2)		
	2014	2015
discount shared	no	yes
Billed amount	$22,809.05	$22,809.05
PPO discount	$-	$18,041.91
Net Amount	$22,809.05	$ 4,767.14
Deductible (employee pays)	**$ 350.00**	**$350.00**
Amount remaining	$22,459.05	$ 4,417.14
co-insurance	10%	25%
co-insurance cost to employee	**$2,245.91**	**$1,104.29**
maximum out-of-pocket	$1,500.00	$ 1,500.00
Employee total cost	**$1,500.00**	**$1,454.29**
Employee savings		**$45.72**

Example 4 Hospital in the broad PPO network (Tier 2)		
	2014	2015
discount shared	no	yes
Billed amount	$2,015.45	$ 2,015.45
PPO discount	$-	$810.21
Net Amount	$2,015.45	$ 1,205.24
Deductible (employee pays)	**$ 350.00**	**$350.00**
Amount remaining	$1,665.45	$855.24
co-insurance	10%	25%
co-insurance cost to employee	**$ 166.55**	**$213.81**
Employee total cost	**$ 516.55**	**$563.81**
Employee savings (cost)		**$(47.26)**

BENEFIT FAIR CALENDAR

Do You Have Questions About Benefit Plans Available To Eligible City of Chicago Employees?

This is your opportunity to get in-person answers from the following representatives: Benefits Management Division, Blue Cross Blue Shield Blue Choice OPT PPO & Blue Advantage HMO medical plans, BlueCare Dental HMO & Dental PPO plans, Telligen Medical Advisor, Quest Diagnostics, CVS-Caremark prescription drugs, Davis Vision plan, PayFlex FSA plans, MetLife universal insurance, Prudential term life insurance and long term disability plan, Nationwide Retirement Solutions deferred compensation program, Wageworks transit benefit program, Chicago Municipal Employees Credit Union, Chicago Patrolmen's Federal Credit Union and Healthways (Chicago Lives Healthy) wellness program.

BENEFITS FAIRS BELOW

Dates	Locations
Thursday November 6th	**O'Hare Airport** Department of Aviation 10510 W. Zemke Blvd (2nd Floor) 10:00 - 3:30 (City ID Required)
Friday November 7th	**Public Safety Headquarters** 3510 S. Michigan Ave (Multi-Purpose Room) 10:00 - 3:30
Thursday November 13th	**Midway Airport** **AMC Building** 6201 South Laramie (First Floor) 10:00 - 3:30 (City ID Required)
Friday November 14th	**City Hall (1-Day Only)** 121 N. LaSalle Street (10th and 11th Floors) 10:00 - 4:00
Monday November 17th	**DePaul Center** 333 S. State Street (3rd and 4th Floor) 10:00 - 4:00

IMPORTANT REMINDER: The Benefit Fairs listed above are for INFORMATIONAL purposes only.
New enrollment, changing your plan and/or submitting certified documents will not be possible at any of these locations.

ANNUAL HEALTH CARE REMINDER

As required by the Women's Health and Cancer Rights Act of 1998, each medical plan offered by the City of Chicago provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between breasts, prostheses and complications resulting from a mastectomy (including lymphedema). Keep this notice for your records and contact your PPO or HMO administrator for more information.

Questions regarding which protections apply and which protections do not apply from grandfathered health plan status can be directed to the plan administrator at 1-877-299-5111. You may also contact the U.S. Department of Health and Health Services at www.healthreform.gov.

HEALTHCARE CONTRIBUTION RATES FOR ALL ELIGIBLE EMPLOYEES EFFECTIVE 7/1/2006

Pursuant to union agreements, the following formulas are applied to your annual salary with your level of coverage to determine your contribution per pay period.

ANNUAL SALARY	SINGLE	EMPLOYEE + 1	FAMILY
Up to $30,000 (flat rate)	$15.71	$23.88	$27.65
$30,001 to $89,999	1.2921% of gross divided by 24	1.9854% of gross divided by 24	2.4765% of gross divided by 24
$90,000 and over (flat rate)	$48.45	$74.45	$92.87

The following Examples Are Provided To Clarify These Payroll Deductions:

Example 1:

If your annual salary is under $30,000, and you enroll for single coverage, your contribution will be a flat rate of $15.71.

As your salary increases over $30,000, your contribution per pay period will increase accordingly.

***Example 2:**

If your annual salary is $46,000, your contribution will be calculated as follows:

Single	$46,000 x .012921 divided by 24 = $24.76
Employee + 1	$46,000 x .019854 divided by 24 = $38.05
Family	$46,000 x .024765 divided by 24 = $47.46

Example 3:

If your annual salary is $90,000 or more your contribution is capped at a flat rate:

$48.45 for a Single coverage, $74.45 for Employee + 1, and $92.87 for family

* (These calculations can be computed for any salary from $30,001 to $89,999 depending on the level of coverage. As your salary increases, your contributions per pay period will increase accordingly.)

Healthcare Contribution Rates for Veteran Crossing Guards**
Effective 7/1/2006

ANNUAL SALARY	SINGLE	EMPLOYEE + 1	FAMILY
Up to $30,000 (flat rate)	$20.95	$31.84	$36.87
$30,001 to $89,999	1.2921% of gross divided by 18	1.9854% of gross divided by 18	2.4765% of gross divided by 18

**Hired prior to January 1, 2006